

## Disability Living Allowance reform consultation – online responses

Respondent Number	Response
ONLINE1	<p>1) Obviously physical barriers such as being paralysed, in a wheelchair etc, but mental barriers are as powerful a handicap and in most cases the sufferers feel as immobilised and helpless as someone with severe physical difficulties</p> <p>3) Travel expenses to hospital and clinic appointments wear a big hole in the pocket of chronically ill people.</p> <p>5) It is fair that some medical conditions in themselves warrant that the individual cannot possibly live a normal life without help, and this has to be taken into consideration with any assessment. However, as certain conditions vary in severity and people react differently to their conditions, tailoring the benefit to the individual's needs through assessment seems the right thing to do, as long as the long term condition is fully understood by the assessors.</p> <p>6) Basic life skills, eg handling money, navigating a journey to a shop and home, being able to communicate if the person is in trouble. These basic social skills are essential for everyday life. Without them, even the most able-bodied person cannot function without help from another.</p> <p>7) By not taking medical professionals advice as their main port of call. Sometimes, even the disabled person cannot adequately explain how they feel from one day to the next. The main caregiver is the person "on the scene" for most days to give a good picture of fluctuations in the individuals needs, and should be main consultant on the matter. It should then be up to the assessors to realise that while everyone has their good days, the bad ones are really what the assessment should focus on...this is when the new benefit really should do its job to help the individual.</p> <p>9) Just simplify the form basically. Bear in mind that a lot of people filling in these forms about themselves have learning difficulties and mental health problems. An example of ridiculous questions for such individuals on the current form is "How many minutes per day do you have this difficulty?"</p>
ONLINE2	<p>1) talking to those going through the process and listen to those who get rejected on bureaucratic grounds</p> <p>3) Disable people in most cases need someone to accompany them around and help their with much of their travel needs to access community services. Also a lot cannot travel on public transport. Down syndrome and Autistic people fall in this category</p> <p>5) i strongly believe some condition should be automatic.</p> <p>6) everything that has to do with basic needs is essentials. accessing community services also is important</p> <p>6) People born with Genetic condition that prevent them to have all the necessary faculties to live an independent life should not have to fill and answer so many questions. its really demeaning to them. Condition like Autism and Down syndrome should qualified for the higher rate from bith.</p> <p>8) yes this should happen. Many disable person needs special equipment and adaptation to their environment.</p> <p>10) Gp, social workers and the carers and any body else looking or in contact with the person concern</p> <p>17) children needs should be assessed with the help of their carers and through professionals working with them</p>
ONLINE3	<p>1) Being disabled with secondary progressive Multiple Sclerosis and unable to do anything for myself</p> <p>2) Yes everything should stay the same. the allowance we get is just about adequate.</p> <p>3) Transport and adaptations to the home and surrounding areas.</p> <p>4) Yes I don't know of any</p> <p>5) Base claims on specific needs and review regularly</p> <p>7) By reviewing regularly with people with the correct qualifications for the disability concerned</p> <p>8) No</p> <p>9) By using WELL qualified people in the disabilities involved</p>

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ONLINE4	<p>1) The posing of this question casts into doubt the validity of this whole proposal. This whole document is a proposed solution to aid the disabled but this question is seeking a definition of what disabled means. I would have thought that the answer to this question defines the problem and would need to be known before the rest of the document could be written.</p> <p>3) Costs should not be considered as a defining factor. DLA provides additional resources that makes coping easier. Without it many would not incur extra cost as they don't have the income. They would simply have to either stop doing certain things or have to struggle through the pain, fatigue, embarrassment or hurt.</p> <p>4) Removing one rate from one component may reduce the number of permutations, but to be honest I cannot see that having a significant impact on the administration. You will still have 8 possible boxes to slot people into. Why not do away with lower rate mobility, which is essentially a subsidy for those that need care when travelling. Have a single mobility band equivalent to the current Higher Mobility, and 3 care bands incorporating lower mobility. This would give 3 care rates or 3 care rates with mobility.</p> <p>5) An illness which is degenerative and progressive with no treatment, such as Primary Progressive MS, is only going to worsen. Whilst the rate of deterioration is variable it is also inevitable. Once the initial award is made it would be wasteful to review and reassess except when the person feels they need additional help.</p> <p>6) The answer to this question should have been included in the terms of reference when formulating this proposal. If you need to ask it at this stage it suggests to me this proposal is flawed and I'll be prepared.</p> <p>7) If by conditions to mean the medical condition causing the disability then there needs to be some categorisation. Assessment and review frequency should be variable depending on the condition. In the same way that an amputee will never grow a new limb neither will someone with a progressive degenerative illness recover. The review frequency for these should be at the request of the sufferer when they need more help leaving the review resources free to track curable shorter term conditions.</p> <p>8) I receive DLA as I can only walk short distances slowly. I will eventually need use a wheelchair. If that chair means I can travel further, faster and was taken into consideration would I find myself getting worse but losing benefits because of the adaptation.</p> <p>9) The old form was repetitive, requiring the same responses to many questions. It could be simplified, however, I would say that it was made daunting and difficult more by reputation than by content. As my condition deteriorated and a claim for DLA became a possibility and then reality everyone talked about the form as a minefield. Health professionals and volunteers all expressed dread, not about the form, but about how your answers needed to be composed perfectly or the assessor would reject your claim. I found nothing wrong with the information provided and fully understood how it worked, the negativities were all related to the reputation of the DWP's assessors and their processes. Why should I be advised to speak to Welfare Rights and Citizens Advice before filling in a fairly , long , but simple form? Because of how the answers would be read, not because of the questions.</p>
ONLINE5	<p>1) Being tagged 'Disabled' the term is too widely used. I feel words such as incapacitated are more appropriate to many.</p>
ONLINE6	<p>1) Until the attitudinal bias in General Society and the continuing discriminatory use of the Medical Model Of Disability remains with policymakers and government, there will always be barriers preventing people with disabilities fully engaging within our society, a simple argument of this is the continued practice of treating people with disabilities in England to pay for GP Prescribed Medication when in Ireland, Scotland &amp; Wales people with disabilities are given free prescriptions, this flies in the face of the DDA 1995/2005 and also the Equality Act 2010.</p>
ONLINE7	<p>1) The illness itself  Lack of confidence and ability  Social isolation  Lack of transport  Society's lack of tolerance of difference  Lack of help and understanding of systems/ignorance of help available</p> <p>3) Paying for help with tasks others are able to carry out themselves.  Cost of travel e.g. to hospital/other health-related appointments.  Increased living costs e.g. extra heating.</p>

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	<p>4) This will not simplify the system for the client, or reduce bureaucracy. Potential for people with lower needs to receive no benefit at all, and for others to have to have constant reassessment.</p> <p>5) All claims should be based on the needs and circumstances of the individual, however there should perhaps be a presumption for entitlement in certain cases e.g. blindness.</p> <p>6) Links to Adult Care need to be made for those applicants with less ability to carry out essential activities. Essential activities: ability to look after yourself prepare food keep warm moving around social interaction</p> <p>7) Our understanding of the existing system (taking into account how often someone struggles with a task) is that it works well.</p> <p>8) Aids and adaptations should be taken into account, however it should never be assumed that having this equipment enables a person to achieve a 'normal' life. Applicants should be made aware of aids/adaptations that might be available, and where appropriate link in with Adult Care, but this shouldn't be what determines the outcome of a decision.</p> <p>10) The present system incorporating evidence from the applicant, GP/other healthcare professional, and person who know the applicant best seems to work well.</p> <p>11) What level of qualification would these healthcare professionals have? Independence of healthcare professionals is problematic where payment for the service is involved i.e. Atos. Can these healthcare professionals make an accurate assessment of an individual's needs and abilities in a 5-10 minute consultation? Face-to-face assessments would be inappropriate if sufficient evidence has already been provided in order for a decision to be made. Routine use of face-to-face assessment would be inappropriate due to massive cost implications.</p> <p>12) Nature of the condition should determine frequency of review, e.g. hip replacement or illnesses it is presumed can be cured should have shorter review dates than progressive, long term conditions with no prospect of change. Where someone is awarded higher rates of benefit, and their condition has a worsening prognosis, there should be no call for review.</p> <p>13) There is a presumption throughout the consultation that this system will be 'easier for individuals to understand' - not sure how this statement can be justified. People could be encouraged to report changes with clearer, more concise information provided during the application and/or reminded clearly in annual award letters.</p> <p>?) Application for disability benefit could be combined with Adult Care assessment and vice versa. When passporting to other benefits/services, information should be shared between agencies subject to client consent to avoid unnecessary duplication.</p> <p>?) Changes to the Disabled Facilities Grant system and changes to criteria for Adult Care will make it increasingly difficult for disabled people to access public funds for aids and adaptations. Additional one-off payments for equipment through the PIP system could work.</p> <p>?) DWP should be required to identify and offer help to the most vulnerable claimants to access their entitlements. However, the claimant acting on that advice should not be a condition of award. Key feature of such a system would be one-to-one support, explaining fully the outcome/benefit to client.</p> <p>?) Existing system does not incorporate checks across the whole benefit systems to ensure claimants maximise their income. Passporting does occur to external bodies e.g. Warm Front but claimants of DLA are not routinely informed of what schemes they can access in this way.</p> <p>?) It is not apparent from the proposals whether or how a PIP system would be simpler for a claimant to understand and navigate, or how such a system would overall reduce the bureaucratic burden currently found in the DLA system. In particular, the introduction of additional assessments and regular reviews would appear to add an extra layer of complexity to the current system.</p> <p>?) Signposting to other relevant organisations e.g. appropriate voluntary sector partners,</p>

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	<p>Adult Care, other benefits, subject to capacity and funding.  Any advice or information given should be clear, concise and pertinent.  ?) Unless accompanied by an increase in the rates of PIP from DLA rates, disabled people on low incomes would be disadvantaged if they were no longer passported to additional premiums on means-tested benefits. Not passporting to other services would reduce the overall support accessible to disabled people, and potentially increase duplication of assessment.</p>
ONLINE8	<p>1) Many disabled people (not only physically disabled people) are unable to access community activities, e.g. adult education, social events, entertainment, medical appointments, holidays....in fact, all those types of activities which non-disabled people take for granted, without support from others. Public transport is a good example of something which many disabled people are not able to use easily, either because it is too expensive or difficult to access for physical and geographic reasons. In these cases, the DLA mobility component can help towards the cost of private travel, e.g. taxis or friends or support workers (i.e. petrol and parking).  Safety is an important factor - many disabled people can be put at risk without appropriate support and safety arrangements.  Other members of society: very often there is a total lack of awareness or understanding and an unwillingness to engage with disabled people, be they physically or intellectually disabled.</p> <p>2) Care and mobility components should be considered in all cases.  Personal Independence Payment should not become a means of dis-involving specialist support and protection via a vis delivery of services.  CARERS must be involved in the discussions. Most Carers are not able to afford many of the things which are needed by people who are disabled or who have long-term and terminal illnesses.  People living in residential care are left with very little money of their own after deductions are made from their DLA to contribute to the cost of their care - that is what the Care Component is for, after all - it is essential that the Care Component continues to be available for those in residential care as well as those who living either with their families, Carers or who are trying to manage independently but who, nonetheless, require some support for their care.  Mobility component should definitely be maintained, where appropriate.</p> <p>3) Many disabled people have to pay for extra help - or their families or Carers do, if they are not receiving help from their local authority. This can be as simple as paying someone to help them get to hospital appointments, since it seems there is little or no support available for Disabled People to get to their appointments, which are often far from where they live.  Extra expenses could include: food for special diets (it is becoming more common that NHS/PCT's will not pay for special dietary products by issuing prescriptions, extra clothing and laundry costs (e.g. those with incontinence), holidays where they will have to have someone with them as intellectually or physically they may not be able to cope as a non-disabled person would.</p> <p>4) Won't this simply mean more confusion and more expense to administer?  How can we be sure that ONLY those cases with genuine needs are going to benefit from the changes and that those people who may not be able to answer for themselves are not left out?</p> <p>5) Should be based on the Individual in most cases.</p> <p>6) It's about looking at what most non-disabled or well people take almost for granted.  Example: being able to go to the cinema, go to the shops, go on holiday, go to work, take part in sport and leisure activities...  Ask the individuals what they want. For those who are unable to communicate their wishes or thoughts, give them the necessary tools and encouragement to speak.</p> <p>8) Yes, it should consider what they use already and allow for future aids/adaptations - condition may change. In some cases, it may even improve.</p> <p>9) What about some interactive forms? consider some of the media used in special needs education and in settings for people with sensory disabilities.  Ask Carers too.</p> <p>?) Share information across difference agencies and services. Avoid having to tell the story over and over again.</p>

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ONLINE9	<p>1) often employers hesitate over the cost to the company of employing disabled people and the fact is in most cases the amount of benefit and passported benefits means that they will be worse off in work.</p> <p>2) No</p> <p>3) transport to and from hospital appointments is one extra cost especially if you are working as help with these costs is usually only given if you are claiming an income based benefit. It's ok if you are travelling to a local hospital but if like me you travel somewhere further afield on a daily basis for treatment it is expensive.</p> <p>4) It depends what you mean by key activities as some such as filling and boiling a kettle or carrying a light shopping bag don't mean there isn't a serious health problem. It could put more people who need it genuinely out of this particular allowance.</p> <p>5) Some health conditions should definitely be automatic but only for a set period, such as people on dialysis and also cancer patients who are undergoing treatment such as chemo and radiotherapy as these are conditions which can be/are fatal. I don't think it is arguable that these groups need the help. Currently on DLA people with conditions such as cancer can only be given an automatic "pass" if they are terminally ill with a time limit of 6 months which is outrageous. If the system is to be reformed let's show some compassion.</p>
ONLINE10	<p>1) The lack of supported employment so disabled people can work.</p>
ONLINE11	<p>1) Perception that people with learning disabilities aren't capable of doing anything so therefore can't get jobs etc. That despite DDA etc there are still so many places inaccessible and disabled gadgets and aids are so expensive. Even to do "normal" things such as holidays is expensive - having to pay extra for someone else to help/support you. I use my care component to help me offset these costs; not as a supplement for my benefits as you rightly put it!</p> <p>attitudes is the biggest barrier but also the lack of funding for people to support you to do things properly i.e., social workers TIME - not just half hour visit every 6 months etc.</p> <p>2) not currently</p> <p>3) extra support for getting around - as in carers to push you if in a wheelchair and the costs associated with that. Maintenance of DECENT equipment; not just the basic wheelchair one is given after they lose power in legs. Also think transport costs in general on trains etc and also often longer routes etc getting to places.</p> <p>I know as a worker in care that some people we support can walk with no problems but if they were to lose their "mobility" component - lower level then it would mean them having to pay for a 2nd person on buses etc... all extra costs for people who often are living on basic benefit due to no physical fault of their own but their other medical conditions such as severe epilepsy means they can't be mobile independently without supervision in case of severe injury. It would be these people I would be worried about being kept out of a "loop"</p> <p>4) Yes I think the 2 tier systems will be easier and whilst I understand that some structure of who is covered in what area I would also like to see that these decisions are made in interviews through person to person and NOT through a tick box computerised system as it can then take out the whole personalised way of dealing with people with disabilities and that some days people may fit more boxes than other days... especially in the areas of remission and relapse conditions which can do both these things in the same week at times.</p> <p>5) I think that it should always be based on needs and circumstances of the individual applying. I feel this means there would be no arguments of boxing people into categories - very much a medical model of disability point of view and not social model of disability</p>
ONLINE12	<p>1) Society's attitude to disabled people, the fact that we live in a society where the public are encouraged to sue if anything is wrong thus making public services nervous about allowing disabled people to use their services. Where has the empathy and common sense gone? The world has gone health and safety mad.</p> <p>3) Disabled children if not excluded from services are charged extra where ever they go - childcare, activities because they need extra staff or one to one.</p> <p>Clothing and having clothing adapted.</p> <p>Adaptations to house and relocation - some adaptations have been funded through Disabled facilities grant which we had to wait 2 1/2 years to get, but they were basic, and we had to actually move house first to a house better suited to disabled child and take out a new mortgage.</p> <p>5) yes I think in certain situations where someone is severely disabled or has a life</p>

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	<p>threatening condition, then it would be unfair for them to have to complete a long winded form.</p> <p>6) I think we should stick to the care component - how much care a disabled person needs. You may have an autistic child who is leading a "full and active" life, but that will necessitate them having a carer with them, so just because you lead a full and active life doesn't mean you don't need help.</p> <p>I would look at independence - who can dress themselves, go to toilet themselves, cook, get out and meet people.</p> <p>Many parents of disabled children have given up their jobs/compromised on careers in order to look after their child, and the DLA money helps keep them afloat.</p> <p>7) It has always been my opinion that the DLA forms should be signed off by a local health professional who knows that person well. They can then inform the Gvmt if the condition fluctuates. Its all about communication between Health and Government depts - something that has been sadly lacking over the years.</p> <p>8) You haven't made it clear - are you talking of increasing DLA to those that require aids, or punishing them for requiring aids?</p> <p>I do think that people who require certain aids eg wheelchair should benefit more. My daughter has mobility problems and needs a kay walker, and has been assessed for a wheelchair. She hasn't got one yet, as we're not ready for it, but I do think that if you have the same mobility problems then you should be treated the same - I know other families who have put their child in a wheelchair - and that says more about how they treat that child rather than how disabled she is.</p> <p>My daughter is obese due to her disability and I want her to have the opportunity to walk small distances when she can, rather than be stuck in a wheelchair all day. But she shouldn't be penalised for this</p> <p>DLA should be based on an informed medical opinion - not parents who are too subjective.</p> <p>Aids to be included : wheelchairs, kay walkers, guide dogs, hearing aids, closomat toilets ( special toilets that wash, and dry bottom for those that can't do this themselves), hoists, special bathing aids</p> <p>9) Make it shorter - there's a lot of repetition</p> <p>A lot of the information could come straight from medical professionals/school/social work etc- get depts to talk to each other - parents input should be minimal.</p> <p>Communicate new benefit through carers group and parents forums ( funded through Aiming High)</p> <p>10) lead HP, or with children the paed consultant. in terms of ability with independence - someone who has visited home eg OT/physio</p> <p>11) difficulties are that disabled people and their families already have lots of appts to attend,so this will add extra pressure.</p> <p>It would make sense to add it on to another scheduled meeting - eg annual statement review or paed review</p> <p>13) threaten them with removing PIP! Get HPs involved in feeding back changes in condition</p> <p>?) Families with disabled children are under lots of stress, with other children to consider. It used to be the rule that children under 3 with mobility problems weren't eligible for DLA - I think this is wrong - my child's disabilities were diagnosed at birth.</p> <p>Children tend to have very regular appts so HPS have up to date picture of that child and can feed into PIP process.</p> <p>Families have lots of Appts and don't need more.</p> <p>?) makes it more difficult accessing info, people don't access things that need and causes stress and worse health outcomes</p> <p>?) NO, I don't claim benefits - I claim DLA coz my daughter needs it.</p> <p>?) We waited 2 1/2 years to be assessed for a disabled facilities grant from local council. They are ineffective and paper pushing exercises. More money should be pumped into the actual grants and the assessment by architect, and a lot less on admin. But this is where adaptations should be funded, not PIP which I see as DLA - day to day living. However if it means not waiting 2 1/2 years then maybe this is better idea - would have to see how it works - if you qualify for grant anyhow, then you should not have to use PIP</p> <p>?) yes has been quite useful info about bluebadge and carers allowances and motability. this should carry on - Once you're in the system, you should receive communication about all the benefits you may be eligible for</p>

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ONLINE13	?) yes has been quite useful info about bluebadge and carers allowances and motability. this should carry on - Once youre in the system, you should receive communication about all the benefits you may be eligible for
ONLINE14	<p>1) Society's negative attitudes reinforced by the media targeting disabled people as 'benefit scroungers'</p> <p>Physical barriers - and I don't just mean non-dropped curbs, fire doors that are too heavy to open, cold air-conditioning which triggers Raynaulds, air-fresheners and perfume which trigger asthma.</p> <p>Pathetic employment laws which allow employers to get away with relocating business functions to the other end of the country in order to make recently disabled people legitimately redundant. Avoid any claim under the DDA by using the "relocating for business reasons" excuse.</p> <p>The disability/disease itself - if you have a progressive, painful, debilitating condition which makes you feel like a normal person with a bad bout of flu, you don't have the energy to participate in society even if you want to. If chronic lung disease means you can only walk 5 steps before sitting down to recover, or speak 3 words before needing another breath, you can not lead a fully active life, regardless of the amount of support give. If you have autism, the part of the brain which allows you to understand and participate in society doesn't work.</p> <p>2) 2 levels of mobility and 3 of care should remain. Options to be awarded for life or review at intervals depending on prognosis should remain. Ability to appeal bad decisions must remain. Ability to request assessment by qualified specialist must remain. Ability to use award as as passport to other benefits should remain.</p> <p>3) Additional equipment, additional heating, prescriptions, extra laundry, specialised software, extra transport costs for inaccessible public transport, extra delivery charges for inaccessible shops/public places</p> <p>4) 2 rates will make it more difficult to give an appropriate level of support. You need a night-time rate, and two day-time rates for effectively full-time day support or part-time day support.</p> <p>5) Definitely. Terminal, incurable, progressive diseases should automatically qualify as now,</p> <p>6) Shelter, food, warmth, social contact and the ability to contribute something back to society.</p> <p>8) Yes it should take into account ONLY those aids and adaptations which are currently provided. Items which are 'easy' for me to obtain will not necessary be easy for a less capable individual. Possibly consider a penalty system whereby the NHS has to pay the benefit for people waiting for OT assessment (waiting list 3-6 months) and provision of aids (waiting list another 3-6 months). If those aids would enable the individual to switch categories.</p> <p>9) Move the responsibility for form filling away from the individual and back onto the medical professionals. Make it simple form for a GP to complete, like a sick-note, and counter-sign it by a report from a consultant in rehabilitation or occupational health. Also ensures every claimant is properly assessed for rehab/Occ Health point of view and should result in access to any possible helpful aids and interventions.</p> <p>Information - make it a duty on all GPs to suggest applications are completed and provide persons at the surgery to assist with completion. This should result in a lot more applications.</p> <p>11) The healthcare professional must have relevant experience in the particular area of disability. For example, if assessing an adult with autism, the assessor should have not just a general nursing qualification for example, but a specific qualification in autism and 5 years relevant experience dealing with autistic people. Otherwise, the healthcare professional is no better placed to judge the true extent and impact of the disability than Joe Public. Reports for qualified experts in the field who know the individual concerned are likely to be much more useful, accurate and relevant - this is supplementary evidence already provided as part of an existing DLA application.</p> <p>I am concerned that exposing some individuals to a face-to-face interview, wherever held, will put that individual at risk. Individuals with autism/mental health issues can become violent when stressed, either by being in an unfamiliar environment or by meeting a stranger. Showing a need for DLA by thumping an assessor, damaging a waiting room and putting other disabled people at risk, then being arrested for GBH is a possible outcome. There should be a way for these kind of potentially violent disabled people to opt out of the</p>

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	<p>face-to-face assessment requirement on provision of supporting evidence from their consultant/GP/Mental Health Worker.</p> <p>12) The natural history of most diseases is well known. A person on renal dialysis will remain on dialysis until having a transplant. Their needs are unlikely to change, so would not need reviewing until their circumstances change. A blind person stays blind, a mentally handicapped person stays mentally handicapped. Persons with conditions which progress or remain stable, don't require automatic review. Persons with conditions which may improve, do require review. The review frequency should be based on medical evidence as to the likely degree of improvement. For example, if a person has been injured, is following a rehab program and is expected to regain function, it makes sense to review annually until no further improvement in function were expected and then review much less frequently.</p> <p>13) This is a false assumption. Not all people are able to identify and report changes. To do so requires a degree of cognitive functioning and insight. A mentally ill person in the grip of an acute attack of mania lacks the insight to report a change. A mentally handicapped person may not have the cognitive function to identify that their needs have changed or be able to report on them. I would pass the responsibility of notifying changes on to the lead healthcare professional, given that most disabled people are in regular contact with one/more professionals this should not be a problem. The professional should complete a yearly form stating that the person's condition was better/the same/worse. And both the professional and the disable person should be notified that this form was due. I am deeply concerned that a non mentally competent person could be prosecuted for failing to recognise their condition had changed and then for failing to report it. If there is a power of attorney in place then this could be used to identify persons in need of help and incapable of managing their own affairs, including dealing with the DWP.</p> <p>?) Presumably there would be a lot more paper-work and administrative cost for both people and providers when trying to work out if people were/were not eligible. It makes sense to have one passport, but only if that passport is accepted as credible.</p> <p>?) Through charity, through friends and family, through pre-existing savings and through DLA. Yes PIP should be able to be used to fund one-off purchases. Ideally all aids and adaptations should be provided free of charge.</p>
ONLINE15	<p>3) In my own case I suffer with MS which can have a variable level of impact on my daily life. The biggest cost for myself associated with this condition is the ever spiralling cost of petrol as my personal degree of mobility is impaired. I find the current level of DLA I currently receive (lower mobility) goes someway to offsetting the cost of having to use the car to travel anywhere, even locally due to the ataxia associated with my conditon.</p> <p>4) Only having 2 rates per component must by definition make the PIP less flexible than the current DLA to reflect accurately a wide range of needs and abilities?</p> <p>5) Surely a move away from "automatic" entitlement will innure much greater administration costs? Thereby defeating one of the primary objectives of this exercise, namely cost cutting!</p> <p>9) In my own case (a recently retired engineer) I found the application proccess very protracted and anoying. Eventually going to a tribunal where I was unanimously awarded lower rate mobility DLA (for life). The whole poccess would have been simplified by going to the Tribunal in the first place! Which I believe is what is being proposed.</p> <p>10) Surely the opinion of an individual's consultant should be sought, not just their GP's who may not see the individual for months at a time and not always for the related disability.</p> <p>12) Again a consultant's opinion should be sought as to the likelihood of any future prognosis for a given condition.</p> <p>13) I see nothing wrong the proposal regarding what are in effect fraudulent claims.</p> <p>14) Some form of recognised advocate (not for profit) would go a long way to helping with this process.</p> <p>17) Unable to comment as this quetion is outside my field of experience.</p>
ONLINE16	<p>1) There are shortages of lipspeakers for the deaf people, and they are very expensive. They are impossible to get hold of at a short notice. My mother is a full time carer because of all my hospitals/ doctors appointments which I couldn't do it on my own. This is because the doctors do not understand deafness and time is so limited. For instancee, I report to a receptionist and notify them that Im deaf, they don't bother to pass it on to the doctor and consequently when the nurse calls me which I</p>

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	<p>have no idea and therefore my mother comes with me to every single appointment. I have no privacy or independence.</p> <p>That goes the same with textphones - most hospitals don't have them apart from audiology department. All calls have to be made through Typetalk, again through a third person and NO privacy whatsoever!</p> <p>I have had problems with trains, especially with last minute changes. That is so disorientating. I have to ask a passenger to double check but often they don't understand me or me understand them.</p> <p>It is extremely frustrating for me because I am able to live to a full independent life because the society are not fully deaf aware.</p> <p>2) I think ALL needs to be changed and reformed to a clearer and concise benefit. I have noticed there is NO clear information about deafness at all. Even though the DLA guidelines clearly states that I am classed as 100% disabled. Yet every year it was more and more difficult to claim DLA with the complexity of the form and I have to repeat myself every year which is very frustrating!!</p> <p>3) The extra costs are the aids and equipments that help us to live safely and live independently. Unfortunately they are not cheap to buy. Often we have to go without some of the necessary equipment.</p> <p>To be able to communicate, it costs us more money especially with texting, internet and telephone calls as we take a lot longer than a hearing person.</p> <p>4) The disadvantages of having two rates towards the deaf, you could have one person with deafness up to 80% on the higher rate and other is 100% deaf who is on the lowest rate. How can you justify that and how can you give the money more fairly if this person who is on the higher rate has poor communication skills even though the one on the lowest rate who has limited communication.</p> <p>My point is, this is currently in practice with DLA. I have a friend who is on the higher rate of care as he is severely deaf (80%) whereas I am profoundly deaf (100%), receive the middle rate. How can that be justified?</p> <p>Does it boil down to the right type of person who are processing the form who feels that the applicant should receive the right rate or how much do the processor actually understand in depth about deafness or any disability of any kind.</p> <p>5) From my point of view, I see that blind, people without limbs, people on dialysis and deaf people (above 80% disablement- obtained from Chapter 61 - Attendance Allowance and Disability Living Allowance, 28th Aug 2010) should be offered the benefit automatically because their condition WILL never improve.</p> <p>Sometimes health conditions do improve so thus require assessment over the period of time or it may be fluctuate so it should be reflected on that.</p> <p>I have other health conditions which has affected the quality of my life, and I have not applied for the help on DLA because I was afraid that my benefit would be cut.</p> <p>Reassurances is greatly needed in this to assure people if they develop other health condition(s) then they should be allowed to inform the benefit office without fearing their benefit will be cut.</p> <p>8) Every single item of aids and adaptations including laptops/mobiles that deaf people use in order to live safely and be able to communicate with other people. I can't live without my mobile because it has opened up my world and this has enabled me to get in touch with my mother if I have a problem while Im out driving. I am unable to call out but the texts enable my mother to make necessary calls for me for instance breakdown people.</p> <p>Mobiles are something that hearing people take for granted, but it is my lifeline.</p> <p>The assessment should take into account the aids and adaptations that the person may have and IMPROVE or UPDATE the aids so that they can gain the best from it.</p> <p>9) Don't expect us to write an essay about ALL the problems we have on a daily basis. That was my mother had to endure every year until I had a cochlear implant, that stopped! I find it very insulting that I have to prove that I am 100% deaf which I have been since I was a baby!</p> <p>Don't make it like a DLA, with endless of questions with long answers as this has been stressful enough. Deaf people find it extremely hard to fill it.</p> <p>Keep it short and concise, probably with multiple choice answers. Questions with short answers. All that to be verified in the face to face meeting/evidence.</p> <p>11) I have experienced ignorance from healthcare professionals which I really feel VERY strongly that potential health care professionals/doctors should be qualified in disability, mental health, deaf, blind, so that we are not being discriminated against. I have had</p>

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	<p>friends who had medical meeting subject to their DLA, they've walked away with negative experiences especially doctors being so ignorant about deafness and the frustrations we have to endure on daily basis.</p> <p>Greater understanding of disability does help, as most of us DO NOT want to explain/remind people for instance I have to remind doctors to look at my face when they are talking to me. We don't want to walk away thinking do they REALLY understand what we have to go through every day.</p> <p>Face to face meeting at home - it might be beneficial so that they can see the aids and adaptations, may suggest something that could help us and also its important health professionals should be fully aware of what is available commercially for this particular disability.</p> <p>?) At the moment, some people fund their aids and adaptations through their own money, or via their social services which often be poor quality or substandard.</p> <p>It depends on the type of needs that a person may have, but some people may require constant funding.</p>
ONLINE17	<p>1) Despite the Disability Discrimination Act access and accessibility to goods and services remains poor/non-existent.</p> <p>Governments, local authorities and health authorities do not appreciate that people with disabilities have individual wants and needs. Being a person with a disability is not black and white, there are many grey areas.</p> <p>2) I do not fully understand how DLA is administered now, so I cannot say if there is anything else about DLA that should remain the same. I do not feel self-assessment, under DLA, worked. This system was abused from the introduction and was never put right. Then you have cases where someone with a severe disability be turned down on their initial claim, yet be awarded following review. I feel the middle and higher rate of both components should be retained. I believe the awards of terminally ill claimants should be reviewed after 6 months, if they haven't died from their terminal illness.</p> <p>3) Respite care costs; agency support for themselves and their carer, be their carer a friend or family member, be the support be personal, domestic or social; transport costs incurred getting to accessible services; transport costs incurred visiting family and friends; low household income from carer (spouse/partner) giving up work; low personal budget awards affecting household expenditure.</p> <p>3) Travel expenses (petrol or the cost of public transport) as many of us cannot get about on foot.</p> <p>Costs for activities such as massages and swimming which alleviate our symptoms.</p> <p>Extra costs to pay people to help out with things such as shopping, cooking and cleaning.</p> <p>Costs travelling to hospital, doctors and other medical facilities. Also costs for prescriptions and other medicines.</p> <p>4) I feel the care component is a necessity, it should remain.</p>
ONLINE18	<p>3) Travel expenses (petrol or the cost of public transport) as many of us cannot get about on foot.</p> <p>Costs for activities such as massages and swimming which alleviate our symptoms.</p> <p>Extra costs to pay people to help out with things such as shopping, cooking and cleaning.</p> <p>Costs travelling to hospital, doctors and other medical facilities. Also costs for prescriptions and other medicines.</p> <p>6) Shopping, cooking, cleaning, washing, interacting with others, travelling to see friends and family, leisure activities</p> <p>10) Reports from GP, specialist consultants and carers.</p> <p>11) These people are working to targets and so are unlikely to be sympathetic.</p> <p>13) By tapering off support. A lot of people are reluctant to report a change in circumstances for fear of not being able to cope on less money.</p> <p>Face to face meetings in a persons own home will be especially important for those people with mental health issues who have problems leaving the house.</p> <p>?) I think this is a waste of time as most people on DLA are under the care of a GP or consultant who will offer such support. I also think it is insulting to make people access advice and support when in many cases they will have already done so.</p> <p>I think you need to avoid forcing people to do things which they have most probably already done!</p>
ONLINE19	<p>1) The problems and barriers are immense and almost incalculable. Each set of</p>

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	<p>circumstances are unique to the individual. However, on a general level, modern life is still constructed using a fully able bodied model. If you do not conform to this model, life is extremely difficult. Transport, access even the height of shelves in shops are difficult. I have to plan my daily life around these barriers.</p> <p>2) The payment of DLA works very well.</p> <p>3) Heating your home to a higher than normal level is a major cost. I have arthritis, and even a drop of two degrees in temperature can trigger massive pain. My pain also means that I cannot use public transport. Waiting for a bus is out of the question, and they are so uncomfortable i cannot travel on them. I have a motability car, but still have to pay high prices for petrol, and there are not enough disabled parking spaces. Those that there are are frequently taken by non-disabled drivers. This should be illegal.</p> <p>4) Having just two levels of benefit will result in arguments about the disability of the person. I expect that to move up a level will demand a major decrease in the ability of the claimant. This will make the benefit harder to achieve.</p> <p>5) There are many conditions which, once contracted can only ever get worse. I have arthritis, my partner has epilepsy. Neither of these conditions are going to get better - only worse. I find it objectionable to have to regularly satisfy a doctor I've never met before that I am still suffering great pain in the space of a half-hour consultation. Greater awareness of long-term irreversible disability is needed.</p> <p>6) It is quite easy to calculate the effect of disability. If one looks at everyday life as lived by able-bodied people and then ask which elements of this are impossible, impractical or difficult, these are the areas the benefit needs to address. Like everyone else, I need to go shopping, visit friends and family, and take the many decisions of daily life. Even the smallest things, for example putting on a pair of socks can affect the perspective of a disabled person. Generally, the ability to get out of the house and interact with fellow humans is central.</p> <p>7) I have to ask whether variable and fluctuating conditions are suitable for a benefit such as this. Perhaps there needs to be a new benefit with built in monitoring. Long-term disability at present does not give a right to free prescriptions. Once a condition is identified as life-long, surely we should be relieved of the need to pay for the medication which keeps us alive?</p> <p>8) I have just had to spend money I didn't really have to buy myself a wheelchair, and the difference it has made is remarkable. DLA mobility payments are often taken up fully by providing a car, which is a brilliant scheme, but what is the use of a car if you can't get about when you get to where you are going? It is not difficult to produce a list of aids and adaptations linked to most long-term disability. A new system should look at providing what is needed when it is needed, with the minimum fuss.</p> <p>9) The current form is too long and appears to contradict itself. I neede help to fill it in, and even then it was refused at first, then awarded after appeal. The campaign for plain english could easily advise regarding a form which is client centered not civil service centered. All GPs and hospitals should be able to at least offer a handout regarding what the person is entitled to once diagnosis is complete.</p> <p>10) The person's own GP is the best source of information. They generally have a wider picture of the person's abilities both before and after diagnosis of a long-term disability. Linked with perhaps one other independant evaluation, this should form the basis of the initial decision. However, the independant evaluator's decision shouds not be the basis for rejection of the claim, but rather trigger consultation with the GP.</p> <p>11) Such face-to-face discussions can be very stressful. The feeling of taking part in some kind of "X Factor" scenario can be degrading. How can a disabled person hope to give all the information necessary for a decision in a One-off meeting? Additionally, the stress of this meeting can make the persons condition worse. there are some clear conditions which are obviously life-long and deteriorating which should be accepted without question.</p> <p>12) A simple yearly form such as "has anything changed?" might not be too intrusive. Similarly, it should be easier to access increases of benefits when circumstances change for the worse. At the moment it feels as if the system is geared to removing benefit rather than tailoring it to individual needs. Of course there will be those who abuse the system, there always will be. But this is a tiny minority. At the moment I feel that I have to prove that my enjoyment of life is deteriorating, rather than being offered the full help I need to live the best life I can. Long-term diagnoses should be reviewed on the basis of "what else can we do to help?"</p> <p>13) Change the default of the system from "we're watching you" to "how can we help". A</p>

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	<p>more flexible system will encourage people to keep in closer touch without feeling that they risk losing all their benefit.</p> <p>14) The benefit system is office-based, not claimant friendly. If it cannot be changed completely, then more specialist help needs to be provided so that the claimant can state their experiences in a form acceptable to those processing the information. This means a closer working relationship between the DWP and the claimant. DWP has to become more transparent about what is available and how to claim it.</p> <p>15) There needs to be a closer link between medicine and DWP. Referrals from GPs to DWP officers who then act in the best interests of the claimant, either by arranging a friendly meeting at a local office or in the person's home. At the moment many disabled people feel that they are involved in a sadistic game with the DWP. DWP has the treasure, and the disabled person has to figure out how to get it.</p> <p>16) Absolutely. I recently had to use my credit card to buy myself a basic wheelchair. The repayment of this is going to be hard, and I'm not even sure if what I bought is exactly what I need. I would have loved to have a meeting with an expert to help me decide what I really need, then help to buy it.</p> <p>17) Disabled children not only face immediate difficulties, but increasing difficulties throughout their lives. This should be taken into account from the start.</p> <p>?) A disabled person can spend vast amounts of time and energy (which is often on short supply) in trying to research and apply for the benefits they are suitable for. A one-stop-shop approach would simplify the process.</p> <p>?) I am a post-operative transsexual woman. This means that I might well develop a condition (such as prostate cancer) which would not be catered for under my being recognised as female. Flexibility and a person-centered model is needed.</p> <p>?) Link DLA to free prescriptions.</p> <p>?) Free healthcare - prescriptions, dental, optical etc. should be built in. Also local government funding for adaptations etc. I would rather be turning down help rather than wondering how I can get it.</p>
ONLINE20	<p>1) Public transport not being suitable for wheelchair users along with drivers being ignorant of their needs. Shops with no wheelchair access and even those that do, pack things in so tightly inside the shops that you cannot get a wheelchair around. All in all, wheelchair access restricts where you are able to go. Disabled parking bays being used by ignorant able-bodied individuals, either because they are lazy or happen to drive a big 4x4 vehicle</p> <p>3) It depends on the disability but usually clothing, bedding, shoes, toiletries and petrol as public transport is not always viable</p> <p>5) Some health conditions should mean an automatic entitlement. My daughter has spina bifida and her condition will never improve meaning she will need the use of a wheelchair and carer for the rest of her life. I do not see that we should have to complete a massive pack every few years in order to re-apply. So long as she is alive she should receive some form of disability benefit automatically as should many thousands of other individuals.</p> <p>7) Obtain medical reports from the individuals' specialists not doctor. This would help show who needs the benefits and would also show those that should have no entitlement at all. After all, it is a disability benefit.</p> <p>9) As I stated earlier, those individuals with a medical condition that will not improve, should not have to complete a claim form every few years. It should be an automatic entitlement as long as they are alive.</p> <p>10) The individuals' hospital specialists would provide the clearest reports.</p> <p>12) Reviews are not necessary for individuals with physical disabilities that will never improve</p> <p>13) Make sure they are aware that if they do not do this then their benefit will be stopped for a certain length of time</p> <p>?) Perhaps you could look into doing something about holiday payments. With disabled children, a holiday is one of the few things they can look forward to and get something out of but it is almost impossible for some families to afford any kind of break these days</p> <p>?) You need to remember that the child's disability has a huge impact on the parents and brothers and sisters as well as the child concerned. There should be more help for the families as they are often lost in all of this.</p>
ONLINE21	<p>1) 1. This will depend on the disability is it physical or mental or both.</p> <p>i. If it is a physical disability does the person have access to transport (public transport is lacking once you are away from major cities or large towns) does the person need a carer</p>

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	<p>to support them when they are away from home. If they are capable of working will their employer give them the support that they will need during their time at work. (A company I used to work for had their offices on the first floor and to accommodate a disabled person they converted a ground floor area unfortunately this meant the disabled person was then kept in isolation from his colleagues, best intentions etc.). The other major problem is access to buildings/toilets (ie. Steps stairs pavements car parking). If the person has sight impairment and has a guide dog are there facilities for the guide dog.</p> <p>ii. If the person has a mental health problem they may well need more support when interfacing both in the workplace and in a social environment.</p> <p>iii. The costs involved in being disabled are greater for some and this will preclude disabled people from participating in activities that the average non-disabled person takes for granted.</p> <p>iv. This proposal is supposing that councils/county s/adult care will have sufficient funding to continue to give the limited assistance they provide at the moment.</p> <p>2) 2. This is an ambiguous question, in the introduction it states that PIP will be a direct replacement for DLA if this is true then the implementation of PIP will not make any changes to those in receipt of DLA .</p> <p>I. The present system of 11 variations of DLA allows the system to cater for differing levels of disability</p> <p>II. This means that the higher levels of disability get a higher level of support.</p> <p>III. The proposed changes seem to mean that a person will be categorised as a level one or level two this will then reduce their DLA (PIP) entitlement unless there are subcategories within the two levels.</p> <p>3) 3. This would cover a range of issues that will vary depending on the level of disability and what level of support (Adult care, NHS, various charity organisations) is available and accessible in the persons area. Major costs are:- Care, Heating, Mobility, Home modifications to meet the disabled persons needs, Home maintenance, Respite care (if you can find it ), Holiday costs if a carer is required to support the disabled person whilst on holiday.</p> <p>4) 4. This is in part covered by question 2 but the main drawback of only two rates is that the present system allows for differing levels of disability but with only two rates available under PIP the person will either be on the high rate or the low rate. If there are going to be subcategories within the two rates then the system will not an improvement on the existing system.</p> <p>5) 5. This should be automatic; as soon as you start looking at needs and circumstances you will then bring in means testing as a means to reduce a person s entitlement.</p> <p>6) 6. Why should a person s entitlement be prioritised the individual should decide their own priority as to what they want to achieve. As far as the system is concerned their entitlement should be comparable to an abled bodied person and the resources should be available to enable them to achieve that aim.</p> <p>?) The individual/guardian/attorney need to be made aware of what is available. This could well take the form of a requirement on the service providers but should not be a requirement on the end user, this could be managed by the care manager.</p> <p>7) 7. Rely on the persons GP to supply the required information, or the specialist practitioner that has the relevant experience to supply the information.</p> <p>8) 8. This question is based on the supposition that the aids that a person requires are available, to rely on Adult care to supply some of the aids can take many months and for the person to purchase the required aids assumes that the person has access to funds to pay for them. This would then come down to a means test.</p> <p>9) 9. When I filled in the application form many years ago it took over four hours to complete it. An application form doesn t need to be as complex as the present one and more support should be available to assist a person when they need help. The criteria required to qualify should be basic and unambiguous.</p> <p>10) The persons best qualified to supply supporting evidence would be the specialist and GP dealing with the patient.</p> <p>11) 11. A healthcare professional would not be an expert but would be a general of the shelf person. To carry out an assessment the assessor would have to be an expert familiar with the problems that the assessee had to cope with. With respect to discussions in a person s home or other environment as long as the correct support is in place should not be a problem.</p> <p>12) As the qualifying period for DLA (PIP) is one year then if there is the chance that the</p>

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	<p>condition may be cured then a two yearly revue would not be unreasonable, and evidence would be supplied by the persons GP and their consultant, for illnesses such as parkinsons and MS there would be no point in wasting both the persons and the experts time by having a revue as in both instances the condition is progressive.</p> <p>?) 16. DLA isn t much use as a passport to other services as it seems to be treated as a standalone allowance and other services tend to be found by chance they also tend to be underfunded and have limits as to what can be fitted (East Hants have a limit of two hoists in a property) and their requirements have a tendency of using the total income/savings available within the household not the individual s income/savings, this penalises the disabled persons partner who in a lot if instances is also the main carer. If there is a need for other equipment in my experience this ends up being funded by the partner to the detriment of the rest of the family. There also appears to be a lack of consideration of the needs of other people living at the same home when the adaptions are made to assist the disabled person.</p> <p>?) In the early days of the persons disability they have to come to terms with the problems they have just been diagnosed with and then they have the aggravation of filling in paperwork/home modifications visits from adult care, district nurses and the list goes on, so anything that will reduce the stress/strain they are going through would be of benefit. One of the first points of contact via a referral is Adult care but they only seem to address single problems then close the case and then you start all over again. There should be a case manager who will deal with all aspects of the person s problems and they should be contactable for the duration of the persons need, this may well mean that there would be a rest of life support in place. The present system doesn t work with the patients best interest as you have to contact a calling centre then you are referred to a local Adult care centre and someone within the centre will be allocated to investigate the problem, this person may have no idea of the previous issues that have been addressed and will not be familiar with the patients history, this is both time consuming and inefficient. Recently I have had to go through this process on a health and safety issue raised in October 2010 and this has still not been resolved 09/02/11.</p> <p>?) With some illnesses the persons condition will only deteriorate, with others the two yearly revues will encourage people to report changes as those that are cheating the system will be picked up during the revue.</p> <p>?) No comment</p> <p>?) 18. This should be a joined up service, at the moment different departments do their own thing without reference to other services, they complete their particular requirement and consider the case to be closed rather than referring the end user on to other services. This is where a case manager would be of most use.</p> <p>?) 19. If it is implemented and run in the same way that DLA is run the system would not really change and all that will happen is that DLA would be given a different name without taking the opportunity of improving the system to the betterment of the end user, and a reduction in time and costs. The sharing of information between departments has a security risk factor that would need to be addressed prior to the facility being put in place, government departments are not the most secure sites.</p> <p>?) The disabled person should be able to create a passport detailing their needs that would then be made available to the different departments that they have to access, (security???) this would be generated when they are first identified as having a need and would be updated as their needs change for the better or worse. By introducing this type of document the person would not have to re-assessed each time they are referred to a different department, this would reduce the time scales (for changes to be made) and there would be a cost saving as the specialists required for the assessment would only focus on that particular aspect. The end user would be given a copy of all information relating to this passport to ensure that the information that it contained is correct and relevant and there would be a means to appeal to have incorrect information amended.</p> <p>?) My concern is that this is just a money saving exercise at the moment with the different levels/tiers available a person may well qualify for the high level on one component and a different level on the other component , with a system that has reduced components the level of disability required to qualify for any component would be higher, this will have the effect of excluding a lot of people who at the moment only qualify on the lower levels of either mobility or disability, this may well be what the government is attempting to achieve with the changes.</p> <p>?) This would appear to be a self justification for the government to reduce the number of</p>

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	disabled people that would qualify for PIP (DLA). By changing the tiers there will be a large group of disabled people who will no longer qualify for either component and those that will lose the most are the one's on a basic income in the first place.
ONLINE22	<p>1) Lack of real teeth in the Employment Legislation and an enforcement authority to ensure employers give people with disabilities their legal rights. Most employers see the legislation as something to avoid because of cost. In addition the current attitude of the Coalition Government shows their right wing ideology that everybody should work irrespective of their disability. Perhaps you should bring back the Work Houses and have us all sewing mail sacks then you would be happy?</p> <p>2) The DLA is one of the few Benefits that actually works. If my Mobility Allowance were given to some other body to consider my mobility needs that would be a complete waste of public resources. I have already been assessed as being entitled to Mobility Allowance and that enables me to hold down a job. For purely ideological reasons you want to change a system that is working perfectly well and providing thousands of disabled people with personal transport. If you alter this system you will be responsible for condemning these people to chance and potentially imprisonment in their homes. The UK Parliament has enacted the UN Convention on the Rights of Disabled People into UK Law. The DWP may more usefully spend it's time ensuring those rights are enacted and enforced.</p> <p>3) If you have to ask this question it shows the sheer scale of your incompetence in this area. Where would I begin?</p> <p>4) How can having two rates make it easier to understand? This is a cost cutting measure disguised as improved efficiency.</p> <p>5) Yes some conditions should mean automatic entitlement. Are you seriously suggesting that people who use permanently use wheelchairs or walking aids needs to be individually assessed? An amputation of a limb causes mobility problems and additional costs plain and simple.</p> <p>6) There is no need to prioritise, we are entitled to take part in all activities. Your wish to prioritise is a cost cutting exercise.</p> <p>7) How about the radical idea of regular reviews?</p> <p>8) I am staggered at this question. The assessment should be made on the basis persons impairment plain and simple. An aid or adaptation simply assists the person to carry out their daily life. Yet again another veiled attempt at cost cutting. Face up to the fact there are more disabled people with complex conditions who may be unable to work. As scientific advances improve this number will grow. These people never asked to be disabled so treat them with the dignity they deserve. A civilization is measured by how it treats it's poorest and least able. How do you which to be judged?</p> <p>9) 1) Use Plain English and make it available in all the appropriate formats 2) Be positive about the benefit and avoid employing people who see their sole purpose as putting disabled people through as many hoops as possible and trying to catch them out at every turn.</p> <p>10) The person's Hospital Consultant or GP. The DWP uses it's Medical Assessors as a way to avoid paying out the benefit and make us feel grateful for any benefit we get. To call the current approach patronizing would be an understatement.</p> <p>11) Healthcare professionals must be involved as long as they are people familiar with the persons condition and any treatment they receive. There is a myth that if an 'independent' person involved then that gives the process some kind of validity. Actually all it does is result in appeals over 46% of which are upheld. Healthcare professionals work to a code of ethics and should be trusted to make the assessment.</p> <p>12) Where it is indicated the condition is permanent and/or likely to deteriorate then bi-annual reviews. Where it is a temporary condition or a fluctuating condition then 6 monthly or annual reviews.</p> <p>13) This shows a basic lack of understanding of how disabled people think about their conditions. You assume people think rationally about their condition. People are emotional beings and their actions are driven by their emotions. Therefore the onus should be on the body making the payment to have a regular review at which time any changes can be discussed. If a change arises which required urgent assessment information should be given in the appropriate format of who to ring and discuss changes with. The most logical person would be their GP who could then pass on a report to the body making the payments. Disabled people are known to avoid asking for help and 'keep going on' even when extra help would make their lives easier. The ideology of the current Government and these changes will simply foster that attitude which is of course the aim of the</p>

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	<p>changes.</p> <p>?) A Plain English explanation of the process and benefits in the appropriate formats.</p> <p>?) Your fundamental assumption that there is a minority of claimants who might otherwise not take action is flawed. It's the case of the oft repeated lie. If you tell the public often enough there are only a minority of disabled people who under claim then they will believe you. This of course is the basis of your review of this benefit. You want to have as few people as possible claiming the benefit yet are unprepared to enforce existing legislation to ensure employers take on disabled people. Until you solve that problem this assumption remains false.</p> <p>?) With great difficulty especially if you have a job. Yes there should be one of payments where it is proved a piece of equipment will provide long term benefits. The who mobility/disability aids market is a cartel with artifically high prices and salespeople who prey on vulnerable people.</p> <p>?) None they should be assessed based on their need like anyone else.</p> <p>?) DLA has never helped me get access to other services other than a Blue Badge for my car. Being told about the passporting arrangements would be a start.</p> <p>?) Poverty and a disabled underclass.</p> <p>?) A single assessment by a Healthcare Professional who then provides a report to the Payment Body resulting in a single payment to cover all disability related needs.</p> <p>?) This review is driven by the premise that more disabled people can be moved into employment. Yet you have failed to come up with any concrete proposals on how you will give real teeth to a body that will force employers to comply with discrimination legislation. Learn the lesson from the USA. The only thing businesses understand is money. The reason cmpliance is so high in California is the cost of non-compliance is so prohibative. As long as you shy away from this step these proposals will leave more disabled people in poverty and misery.</p>
ONLINE23	<p>1) Disabled people are rightly not prepared to accept being restricted from playing an active part in society disabled people have a constant battle against illness not just for the period of a parliment but throughouyt life if the amount payed is reduced then a disabled person will be restricted from doing this very thing the further econonmic restrictions due to the ressesion and the reductions on resourses being forced on charitable organisations and institutions is a worrying development there will always be disabled people in society as there will be rich people economicly speaking there always as been the way this is not being represented in the press is worrying too the skewed way the current goverment is portraying this attack on people on sickness benefits is akin to the nazi approach in my opinion misrepresentation and asbuse of the media for political bias and its disgusting</p>
ONLINE24	<p>1) access to the necessary support services to facilitate independence has been significantly reduced over the past few years. This has resulted in some disabled people becomming less able to intigrate into mainstream society and has led to them being almost abandoned in thier own homes.</p> <p>2) The DLA awarded for life critera should remain the same.</p> <p>4) If an applicant falls between the two rates then i assume they will receive the lower of the two. As long as there are clear guidelines on what critera meet which level then there should not be an issue</p> <p>11) Previously some of the medical assessments carried out did not take into account a persons mental health. This may still be the case. Any health care professional will only respond to the client as seen that day and some will have fluctuating health issues. Also whoever takes the assessment must have the flexibility to fully asses a person and not just tick a box.</p> <p>12) Reviews need to be at least yearly unless a person has recieved an award for life.</p> <p>13) you need to be clear about the penalties for not informing you of improvements in a persons health.</p> <p>Also by encouraging people to keep in touch will enable you to assess the chnaging needs</p>

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	<p>and maybe increase an award</p> <p>? ) clear guidelines for each section of PIP on what the qualifying criteria are and what evidence is needed to support a claim.</p> <p>Advice on who will be able to assist in completing an application pack would also be useful</p> <p>? ) this could be seen as forcing someone into accepting support that they feel they do not need thereby reducing their independence.</p> <p>? ) Disabled people use a variety of methods to obtain aids and adaptations, including; accessing charities, disabled facilities grants and direct purchases.</p> <p>If PIP could be used for these purposes then any payment will need to be sent directly to the supplier otherwise the system could be open to abuse.</p> <p>? ) The assessment needs to be based on the needs of the child and not the carer/parent of that child. The changes that occur when a child grows needs to be considered and also how their disability will affect them as they grow. Plus how their disability may improve or worsen with age.</p> <p>? ) DLA is very useful in accessing directly linked benefits such as the blue badge scheme and housing benefit claims.</p> <p>IF possible anyone receiving high rate care component of DLA should also automatically receive a priority need with regard to accessing housing regardless of their previous history.</p> <p>? ) This could result in lengthy benefit claims and disputes over eligibility for other benefits. This would have a knock on effect to reduce a persons choices and access to the support they need while a claim is being assessed.</p> <p>? ) PIP,ESA, attendance allowance and carers allowance could all be assessed at once reducing duplication significantly.</p> <p>? ) Those already in receipt of DLA and living fairly independently without support may not understand the changes and fall out of the system by not complying with the changes and information required.</p>
ONLINE25	<p>1) PUBLIC PERCEPTION OF DISABILITY</p> <p>2) EXISTING CLAIMS SHOULD STAY AS DLA WITH THE PERIODIC REVIEWS REMAINING. ALL NEW CLAIMS COULD THEN UNDER THE NEW BENEFIT. A MORE COST EFFECTIVE OPTION</p> <p>3) EXTRA TRAVEL COSTS. HEATING COSTS ARE HIGHER AS DISABLED PEOPLE ARE NOT ALWAYS AS ACTIVE.</p> <p>4) AS THERE ARE 3 RATES OF DLA CARE AND 2 RATES FOR HELP TO GET AROUND I AM NOT SURE IF IT COULD CAUSE PROBLEMS</p> <p>5) AS FAR AS I AM CONCERNED THE ONLY AUTOMATIC ENTITLEMENT SHOULD BE FOR TERMINAL ILLNESS AND NOTHING ELSE.</p> <p>6) AS A WHOLE THE BENEFIT SYSTEM IN THE UK IS VERY SUPPORTIVE TO THOSE WHO NEED IT. THE DISABLED IN GENERAL ARE LOOKED AFTER BY DLA AND SICKNESS BENEFIT. LOCAL AUTHORITY GRANTS AND ADAPTIONS.I DO FEEL THAT EMPLOYMENT IS A VERY GOOD THERAPY AND ALLOWS THE DISABLED TO CONTRIBUTE TO SOCIETY.</p>
ONLINE26	<p>1) the inability to physically access places because of lack of adaptation, money or transport.</p> <p>3) specialised transport - even if living in care homes - the homes do not provide individually tailored vehicles and as they are small businesses they won't now just because you are withdrawing the mobility supplement from people in care homes. Clothing needs. adaptations to homes and relative homes - can't visit grandmother.</p> <p>4) as long as it is clear, fairly administered, and adequate to meet the needs the 2 levels will be ok.</p> <p>5) based on needs of individual - but some conditions its pretty obvious that the need is great so don't put people through unnecessary stress.</p> <p>6) why couldn't i comment on the taking away of mobility to people in care homes - this is a disgusting idea and shows real ignorance of the circumstances of people who make the choice to live in a more supported environment rather than face the loneliness and inadequate care offered by independent living. Care homes are not going to provide transport for all their residents - get real. Get up to speed with the difference between a hospital (short stay and ill) and a care home (long stay and disabled)</p> <p>8) cars and electric wheelchairs - for people in care homes too.</p> <p>11) healthcare professionals are hardly strangers to the disabled and their carers.</p>

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	<p>17) well I could be very mean and say that a parent's home is like a care home - so take away their cars - or get the parents to make a contribution as they don't have to meet the cost of a family car. However I am not mean.</p>
ONLINE27	<p>1) As a wheelchair user the first obstacles are physical barriers, a kerb at a pavement or even a gentle slope is enough to stop me, therefore the Mobility aspect is essential to me - having access to a car is the difference between having a job and being a prisoner in my home. It has been a godsend to me and I would hate to see it tampered with. Why is 65 the cut-off date? I will be disabled for the rest of my life. I will not become well again on turning 65. When I became disabled 5 years ago I was glad that the DLA was there as I had spent 6 months in hospital and it was good to know that my disability was being recognised and catered for. By changing this benefit you are devaluing it in the eyes of able-bodied people and therefore setting back the advances made in recent years in trying to change attitudes towards disability.</p> <p>3) Fuel costs - my condition requires that I keep warm. I get no extra help with this. Access to a car is essential for me- life or death is not an exaggeration. Targeting those with "the greatest need" means that those with less need will obviously get less . However someone with less obvious need may be able to do more and therefore requires more financial help to function in society.</p> <p>4) Having subjective rates of benefits is not going to simplify things. Will I be marked down because I put in a lot of effort to push myself around compared to someone who doesn't try? Who will decide which benefits are given? Medical staff or civil servants? How often will I need to go before an assessment panel and be reminded that I will never get better?</p> <p>5) Yes - certain medical conditions should automatically be given an entitlement to benefit. Otherwise the decision is a subjective one which will vary from assessor to assessor. The assessment may not be on the basis of means testing but what other criteria will be used to assess the need for benefit. Certain conditions require the same level of support regardless of background, or other external criteria. As before, who will decide and what criteria will be used. It will be subjective and will be humiliating for those being assessed.</p> <p>6) Who will assess my ability to eat, drink and plan an imaginary journey. Who has time to do this and at what cost? Will someone have to come into my home, my work place and see how I can manage? I am a teacher and work in several schools. Will someone have the time to find out how I manage in each school. How embarrassing and humiliating! It is hard enough for me to try to ignore the prejudices of others in society without have someone remind me and those I meet that I have a disability and am looking for a handout. At the moment no-one in my professional or social circle know anything about the access I have to DLA.</p> <p>7) I really do not know. There are so many variables. How can assessing everyone be cost-effective? How much time will be spent doing this and how much will it save? I pay tax every day of my working life. The amount I pay is not dependent upon the resources I use so why should benefits be variable?</p> <p>8) Any aids and adaptations which enable a person to function as closely as an able-bodied person should be included. The second part of your question implies a form of means testing. "should we consider those that the person might be eligible for and can easily obtain?" By "easily obtain" do you mean they can pay for themselves. No-one is going to ask for aids and adaptations they do not need. Again who will decide if the person can "easily obtain" something? This is very subjective.</p> <p>17) None. A need is a need regardless of age. Again, constantly assessing someone throughout their life has a huge detrimental effect on self-worth and only reinforces to society one's differences due to a disability. Nothing in the new scheme suggests that it will be an improvement. It will reinforce prejudices from others and harm the well-being of those who receive the 'benefit'. It is means-testing by another name.</p>
ONLINE28	<p>1) As with many things, there are extremes. At on end, some disabilities will be such that greater participation is simply unrealistic. At the other, perceptions may be the main problem. For those in between where there is a disability which is not extremely great, targeted benefits may provide assistance.</p> <p>3) Travel and transport, household bills (for those who are more housebound), mobility aids.</p> <p>4) As ever, one major problem will be fitting those on the borderline into the right category.</p>

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ONLINE29	<p>?) If my husband could not use his PIP as a passport to the Motability scheme, the Blue badge scheme and exemption from the congestion charge, his activities would be severely limited. Although he is unable to work any more as the [REDACTED] of a national charity since his stroke, he still does a very great deal of voluntary work with young people and the Co-operative movement, and he relies on his Motability car (driven by me) to do it. He often has to go to meetings and other activities in Manchester, London and all over the South East region. This would be impossible without his car and Blue Badge. He would have to give up much of his very important voluntary and community work, which would make him very depressed as he is still full of energy and ideas although his body no longer works very well. He would also find it very difficult to attend his hospital and therapy appointments, as public transport in Surrey is sparse and very unreliable. Buses are often late or don't turn up at all due to staffing shortages and absence. There is the dial-ride service, which he has used when I am not available to drive him, but it is slow, limited and inflexible.</p>
ONLINE30	<p>1) From an employment context: Public and personal perception of abilities and the definition of being "unable to work" and how it is applied. The DWP reliance on "medical model" of assessment to measure capacity- usually a GP. The expectation that disabled people can work, and want to, but the lack of commitment to ensure that this can happen and that more flexible work solutions can be offered from employers. Public perception is becoming less of a barrier but there needs to more Government campaigns highlighting the achievements of disabled people in a non patronising manner. True integration, and planning that integration as an essential function of any future plans and ensuring that EIA are part of this. Lack of will to manage the risk of promoting independent living</p> <p>3) Non-financial costs includes: care and support offered by friends, family, carers, that has no financial remuneration attached. Additional costs are dependant on individual circumstances but the core areas of additional costs that may arise are a result of: accommodations and adaptations lack of accessible transport lack of ability to travel independently housing costs-heating,electricity, food etc- if you are unable to live independently the reality is that you may be longer at home condition management outwith NHS- sourcing alternate remedies</p> <p>4) it may be easier to understand but may be restrictive in accommodating a person centred approach. Having fixed rates does not link to person centred approach and therefore the assessment should be index linked to costs, with a maximum payment that may be potentially higher than is already being offered. the daily living element needs to include areas of aspiration that are an expectation of all- e.g employment. the DLA seems to focus on minimum expectations rather than aspirations and if we don't send the message that aspiration important we wont promote it's achievement.</p> <p>5) all conditions will undergo some form of assessment, and therefore subject to needs and circumstances of the individual. there should be an expectation though that some conditions once assessed with need the benefit for life. many of the issues that we currently face in relation to progressing people within society is a result of assumption based on perception e.g people with generic learning disabilities automatically get ESA rather than JSA..why??</p> <p>6) Firstly what characteristics define who these people are? Then consider capacity or potential capacity to able to live as independently as possible. Essential life: personal care and support rehabilitation and condition management building personal relationships and social interaction</p> <p>7) Needs to be regular review that is not onerous and not a repetition of previous assessment. Possible case management approach to measure what has changed</p>

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	<p>what progression or rehabilitation has taken place.</p> <p>9) seek advice from disability focussed organisations and major stakeholders. again consult with major stakeholders to inform and apply good practice. employ a raising awareness team and link with major stakeholders- NHS, Local Authority, Third Sector etc, provide material and presentations, promotional electronic support, identify local champions</p> <p>10) Evidence of capacity and future capacity to carry out essential requirements of daily living Evidenced by Health professionals Friends and family Social Care Personal statement</p> <p>11) Promotes the idea that DWP are still focussing on the medical model of disability and also may be a duplication of existing healthcare input...can the face to face be conducted by health care providers already involved. the inappropriateness of this would be if a health care provider is already involved and can offer the discussion.</p> <p>12) Medical and social care assessment led- and from those who provided evidence for the initial assessment Maximum of 6 months and minimum of 1 year but only for those individuals who have been identified as having fluctuating conditions. for conditions perceived to be more stable, the robustness of the initial assessment should ensure that there is less need to review, however if the PIP allocated included elements of expectation regarding rehabilitation, aids, adaptations, this should be reviewed for result. can the PIP assessment therefore be a working document that is shared by those who provided the initial feedback.</p> <p>13) Consider why people might not do this?? either they don't know, or they fear that the benefit will be removed? Take away the fear, and increase awareness of the need to report changes. There needs to be clear message about what the benefit is for, and give examples of people who receive the benefit that are in work- person who uses a wheelchair, in high paying job- entitled to DLA!</p> <p>14) Firstly don't always assume that people can better manage or improve their situation and make sure that you can identify those who can from those who can't. The PIP should be about current capacity and future capability. offer a multi-agency approach to ensure that all relevant parties can be included and share the data at the outset, and support and promote progression to independance. The only issue with this may be that for those individuals who do lead very independant lives, with disability, that this process does not become overly intrusive either. So don't involve who you don't need to.</p> <p>15) First- make sure that you identify those minority of claimants whose situation may be "better managed" or "improved" then offer support to them as part of a case management approach. support them to manage better and improve Avoid punishment or withdrawal approach - may excacerbate the condition and lead to greater need!</p> <p>16) PIP should inform of appropriate aids and adaptations and how to apply for alternate funding. if no alternate funding is available and the aid would promote better management, living, improvement, should be funded through PIP. and reviewed for result.</p> <p>?) avoid duplication and duplicate funding ?) Think it is essential to adopt a shared approach, that assessment need to be shared across services and organisations Clear recognition about the purpose of the benefits, the expected use, and therefore potential exclusion from other forms of funding, and income. The DWP should link with the LA's/Direct Support/Self directed support - etc to understand the commissioning of care and support, share information and then be able to cascade this information at an operational level.</p>
ONLINE31	<p>1) a)Cost and availability of transport b)Accessibility into buildings c)Availability and reliability of Care companies</p>

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	<p>d)Additional cost of holidays  3) a)Cost of transport e.g an adapted vehicle, very expensive  b)Holidays are more expensive  c)Cost of adaptations in the home/garden  d)Cost of therapies e.g physiotherapy &amp; podiatry  e) Cost of essential equipment e.g hoist, through floor lift  f)Annual servicing costs for equipment  g)Cost of electric wheelchair when not provided by the NHS  4) Having 2 rates within each component will make for even more confusion and could lead to rates being too variable and hence unfair  5) Yes definitely. There should be certain conditions that automatically entitle a person to benefit. some conditions can have a huge impact on the everyday life of a person. Also a condition e.g. MS can vary in severity from day to day. We all have good and bad days. The condition on the bad days must be taken into account  6) a)Washing, dressing, toileting  b)Being able to access food and drink  c)Being able to shop and socialise as the able bodied can  7) It is essential that the assessment be undertaken by a specialist with in depth knowledge and understanding of the condition  8) All aids and adaptations that exist should be taken into account. Also any future needs i.e. wheelchair, hoist, ramps. Where the adaptations within the home have been privately funded, those costs must be taken into account. Adapted vehicles, lifts etc are very expensive  10) The GP, District Nurse, Hospital Consultant and carers who see the person on a day to day basis  11) It depends what is meant by healthcare professional. The person's own GP and especially their Consultant are the people who really know the person. As disability covers such a wide spectrum, no one but the person's GP etc are qualified to make a true judgement of the person's day to day health and how this affects their abilities  12) Of course there should be different types of review depending on the person and their disability.  Certain condition progress faster than others. The frequency of reviews should be guided by that individual's needs over time. Sufferers of the same condition can be vastly different in ability. The needs and abilities of the person, together with discussion with their GP should set the frequency of reviews</p>
ONLINE32	<p>1) My son has Downs Syndrome, had two open heart surgeries, has atrial fibrillation and recent seizures. Suffers with his feet. He gets very tired; is in need of full-time supervision and care and is incapable of participating in a work situation. Health is a serious barrier to an independent life.  2) The mobility aspect should stay the same. Having this all dealt with by a motability company is very welcome to myself as a parent/carer to a disabled adult. Without this we would be virtually housebound.  3) The main extra costs facing disabled people are the high energy costs. My son is at home most days - he doesn't attend centres as he's been assaulted (sexually and physically) on more than one occasion and will not attend anymore. Energy costs in cold weather are terrifying for us. Transport is another problem which motability is meeting now but I'm fearful for the future. As his parent carer I need to take him out to eg bowling or shopping - this can be costly on the pittance he receives. As I receive state pension, the carer allowance has been withdrawn. His shoes are costlier than other peoples as he needs comfort above everything else. His one little indulgence is going to home matches of his football team. Very costly these days. Hospital appointment car park charges are high.  5) It should not mean automatic entitlement but then some people may pretend to prolong their illness to qualify for the disabled benefit whilst others get themselves better and move on. Is this fair? Others with learning disability are not able to pretend like those people and may not qualify for something which on a bad day they should be getting.  6) Those with learning disabilities and or health issues should take high priority. They cannot prepare a meal to feed themselves or shop for food. They need carers to support them round the clock. Then extend the needs to support them outside their homes either in leisure or work activities.  7) So that people have an underlying entitlement and do not have to go through the whole</p>

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	<p>process should they have to go into care or hospital for longer than 28 days.</p> <p>8) These people who rely on aids and adaptations should be provided with the utmost help to use the latest contraptions which would enhance their lives.</p> <p>9) Allow people the opportunity to put their full story rather than just submitting yes or no to a question.</p> <p>10) Even though my son has multiple medical needs and receives medication every month, the doctors at his medical centre are changing constantly and no one actually knows him as it is a big ordeal for him to attend the doctors surgery. Most times I get his prescription. It is highly stressful for him to see the gp or other medical practitioner. Obviously, when absolutely essential he has to go but I don't want to put him under stress when not necessary. So having to do this even once a year would make our lives more stressful.</p> <p>11) My son who has downs syndrome and numerous health conditions gets highly distressed when faced with yet another medical situation so a regular assessment would make all our lives more stressful. As he has a serious heart condition such meetings would not be good for his health or mine for that matter.</p>
ONLINE33	<p>1) A lack of services from the local council which they say is due to a lack of funding from the government!.No support means some disabled people can't go out because they need someone with them and if they can't afford to pay for care from their own money then how on earth can they lead full and active lives? Lack of support,Care,and understanding from the government and society has a massive impact on disabled people and their family's lives.</p> <p>2) All of it why change what is already in place that is quite straight forward and easy to understand? although I do agree with face to face assessments with properly trained doctors and various medical staff.</p>
ONLINE34	<p>5) I believe that some health conditions certainly deserve automatic entitlement as those chosen conditions have evidence already to suggest that they have special needs. It would be unfair to make assessments on conditions we all know already that have special circumstances and also will be a waste of time making our own judgements.</p>
ONLINE35	<p>1) My son has Downs Syndrome. He needs a carer with him at all times. He can not be left alone as he would think nothing of turning on the gas, wandering off and would have no idea what to do in an emergency.</p> <p>He needs someone with him at any social event so that he can understand what is going on, what he's expected to do and to help mediate the spoken environment (he is also deaf). Sadly, people do not queue up to help to look after him, although we do have very close friends and family.</p>
ONLINE36	<p>1) Other peoples perceptions of disability, wheelchair users are particularly vulnerable, public buildings can be difficult to access, public toilets and those in restaurants that claim to be accessible are often too small. Shops are a particular trial, narrow aisles, lifts that can only accommodate the wheelchair user and not the carer. Wheelchair taxis that charge extra, theatres that do not provide enough spaces for wheelchairs, restauranters that are unhappy to have 'such people' taking up more space. Tills that are designated as being for 'disabled' but they are the same height as the other tills!</p> <p>2) Not that I can think of</p> <p>4) I have no doubt that having two rates will make administration simpler, I am not sure it will be easier for the recipient to understand.</p> <p>The disadvantages are that instead of black, white and grey there will just be black and white! I feel there will be many people who only receive the lowest rates will be dropped completely from the system. This will not only save money being awarded, it could reduce the workforce that administers it.</p> <p>5) I was unaware that certain conditions attracted automatic entitlement to DLA, in fact I am surprised as, I have a grandson on renal dialysis, has been for the past 7 years, whose DLA has been taken away, so under the circumstances I feel it should not be automatic. My daughter is currently having to go to a tribunal to try to get the payment reinstated.</p> <p>6) Isolation is the worst part of any disability, living within 4 walls without human communication is debilitating, social interaction is vital. Just because a person cannot move around with ease does not make them moronic or stupid, they often have many talents to share with the rest of society e.g Stephen Hawkin. This Government has it's share of disabled participants, I trust they are consulted for their responses. Look at everyone as an</p>

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	<p>individual, don't be patronising, see the person not the disability.</p> <p>7) Actively listen to those who are in this situation, try to put yourself in their shoes.</p> <p>8) Any that are necessary to enable a person to take control of their everyday needs, bath aids, toilet aids, walking aids, dressing/undressing aids stair lifts.</p> <p>No</p> <p>9) I think there should be two forms, one for personal care and one for mobility, both in plain english, or whatever language the recipient understands. I know there are already Benefit Agency personnel who will assist with the completion of forms but this is not widely known and should be advertised.</p> <p>Posters in appropriate languages in all public places.</p> <p>10) Medical professionals and carers are the best source of information, family members should be included at all costs</p> <p>11) This is going to be an onerous task for a GP, already under pressure to make themselves available for, with the phasing out of the PCT's they will have even less time to spare for this type of exercise. In the case where the person may have a new GP they may not be familiar with the care needs of the person in question. Personally I feel this is a waste of time, a Doctor's report takes enough time to fill in as it is.</p> <p>Yes - see above</p> <p>12) I feel the reviews should be set bearing in mind the original condition the award was made for. Some conditions may change very little for the better, most get worse. Congenital conditions are unlikely to change, so would need a lesser number of reviews. See above</p> <p>13) Make it clear from the outset that there are penalties involved for not reporting changes, maybe at the bottom of every page of the initial form.</p> <p>14) Knowing how to set the process in motion is vital, tell people where to go to get help CAB, Benefits Agency, again a poster campaign would help in surgeries, post offices, pharmacies, libraries any other public domain. Yes it would be helpful to provide this as a part of the benefit claiming process.</p> <p>15) This question is too longwinded. refer to question 14</p> <p>16) Adaptations are partly provided by OT departments or Local Authorities. Other aids are usually paid for (exempt from VAT) by the individual. There could be an opportunity to pay something from the PIP, but I don't feel that would meet all the costs involved.</p> <p>17) Take account of the knowledge about the child from their primary carers, schools and health professionals, including Social Workers, bear in mind that their needs can become greater with age not less.</p> <p>? ) all assessments should be carried out under a multi-agency umbrella with the persons permission, this would not only prevent duplication but would minimise waiting times and use of separate services</p> <p>? ) It has not been a passport to other benefits or services for me</p> <p>? ) 1. It hasn't</p> <p>2. I have no idea</p> <p>? ) clear and transparent policies need to be developed which are open to all persons in need of these services</p>
ONLINE37	<p>1) Pretty well everything in life caters primarily for those who can walk, hold things, see, hear etc. fully normally. Adaptions to enable disabled people to move themselves, care for themselves, drive etc. tend to be very expensive. Although awareness of the need to cater for disabled people as well as non-disabled people is improving, it is at a snail's pace. The DDA did not help in that it gave a 'get out' by saying that companies should make 'reasonable' adjustments. Many companies, especially smaller businesses, see adjustments to allow easy access for wheelchair users, for example, 'unreasonable' and not cost effective, so we still have ramps that are much too steep, sills on doors, dangerously sloping pavements etc. which cannot be negotiated by many manual wheelchair users unless given physical help. Transport wise, we also have no guarantee that the first bus to arrive will have a ramp and driver willing to assist in helping a wheelchair user to travel on a bus. We also have to get to the bus stop first which could be a long way from home and we could get worn out just getting that far. Therefore, for many disabled people, the only sensible option is to use our own car, if we have access to one, or a taxi from home. This costs more money than would be the case for non-disabled people who have other choices. DLA helps with these extra costs. Other barriers include a lack of suitable toilet facilities in many places. If you know, or have doubts, as to whether or not you will be able to make yourself comfortable, you don't go out! These barriers are</p>

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	<p>found in many workplaces, meeting places, transport and places of entertainment. Even doctors' and dentists' surgeries can be inaccessible without help.</p> <p>2) If someone is permanently disabled or likely to get worse rather than better, then the benefit should be for life and not keep needing review unless the disabled person asks for movement to a higher level of benefit. Examples, permanent paralysis, multiple sclerosis deterioration.</p> <p>3) The costs of:  Wheelchairs and other mobility aids.  Adaptions to the home.  Maintainance of above items and adaptions.  Using a car to go a short distance because walking is difficult or impossible.  Using a car or taxi because public transport is unsuitable.  Car adaptions or specialist vehicles plus maintainance.  Personal care if unable to do this independently.  Cost of Domestic help.  Cost of getting to medical appointments that non-disabled people may not need.</p> <p>4) It will depend upon what the difference in amounts is between the rates and what the dividing criteria is as to what problems two rates could cause. It may be less 'black and white' if there were 3 rates for each. Two rates per component should make understanding easier rather than 3 for one and 2 for the other which applies to present DLA.</p> <p>5) There should be some automatic entitlement when someone is suffering from some health conditions and impairments, for example, where permanent disability exists. The rest of the claims should be based on the needs and circumstances of the individual applying.</p> <p>6) The activities most essential for everyday life are:  Those necessary for keeping safe, clean and healthy and retaining dignity in doing so. e.g. keeping an eye on the mentally ill, washing, toileting.  Those that enable an individual to earn/receive enough income to maintain a comfortable standard of living for self and dependants. e.g. driving to the workplace.</p> <p>7) Ask for annual updates from the health professional caring for the disabled individual. (Could be doctor, physiotherapist etc.)</p> <p>8) The use of aids and adaptions should not prevent someone from receiving benefit. If they have aids and adaptions, then there are expenses involved in the upkeep and maintenance of them and possible extra medical appointments. If a wheelchair is used, the person may be able to get about but not with the same ease or at the same cost as a non-disabled person. If prosthetic limbs are used, the person may be able to walk but the fitting of the limbs must be regularly checked involving medical appointments. If someone does not have aids or adaptions and the assessor thinks the person would benefit from them, then the person should be referred to the correct authority.  The assessment should then go ahead on the basis that the person needs the aid or adaption.</p> <p>9) If someone is already receiving DLA for life, then they should not have to reapply for the new benefit. They should automatically qualify for a similar level of the new benefit. If it really is necessary for re-application then it should simply be a case of asking what if any, changes there have been since DLA was originally applied for i.e. a short version of the application form. The application form should have 'yes' or 'no' answers to clear simple questions and a space for an individual to comment on their response if they feel the need to qualify the answer. The questions should all be distinctly different and not appear to repeat each other. Information about the new benefit should be available in all disability magazines and to all professionals and groups catering for disabled people. There should be a TV/media awareness campaign at a level similar to the attention given to 'going digital'.</p> <p>10) The professionals best placed to provide evidence are physiotherapists, specialist nurses (e.g. MS nurse) and occupational therapists employed by the health authority. If someone is seeing one of these on a regular basis, it should not be a problem. The evidence could be in the form of a short questionnaire that will not be too time-consuming for the professional to complete for their patients. The next choice would be the person's GP however, it should be borne in mind that a person may not need to see their GP too often and the GP may not see or be aware of, the problems the claimant faces in everyday life.</p> <p>11) The healthcare professional should be one who has already been caring for the</p>

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	<p>claimant and who is familiar with the nature of the disability. They should not be a complete stranger to the claimant or one who knows nothing of the nature of the particular disability. The 'face to face' should not cause anxiety or excessive cost (transport) to the claimant. It should preferably be incorporated into one of the claimants regular appointments.</p> <p>12) The frequency of reviews should be set according to the nature of the disability and whether or not it is a disability that will come and go, one that will worsen over time or will be short or long term. A long term or lifelong illness that will worsen over time (progressive MS) should have less frequent reviews than a condition where the claimant could recover e.g. mobility problems following a stroke.</p> <p>13) Encourage people to keep a copy of their application form and DWP should keep a copy. When rates are changed, ask for acknowledgement of the change of rate notification and ask for the claimant to answer a simple yes/no question, 'Have any of your circumstances changed since your application or last contact with us which could affect the level of benefit you need, if so, please give details'. A 'reply paid' envelope should be provided for the response.</p> <p>14) Claimants for PIP for the first time may want pointing in the right direction to get a wheelchair, ask for care in the home or get adaptations fitted. It would probably be helpful to provide this direction but only if the claimant wants it. They may already have started enquiries themselves, in which case, DWP should not get involved.</p> <p>15) DWP could provide information but should be prepared to take 'no' for an answer. If a claimant for PIP does not want other help, that should be respected.</p> <p>16) Funding of aids and adaption varies according to means. How does anyone know if a cost is going to be a 'one-off'? Moving home could mean the same adaptations need repeating at each home. A wheelchair may need replacement or supplementing with more than one for different uses. If you take your PIP as a monthly cash amount, surely you can save it to pay for a big expenditure e.g. home adaptations, if you so choose. It just means that you have to fund getting about and any care you need by other means.</p> <p>17) GROWTH!!</p> <p>?) It is very disappointing that many disabled people receiving DLA after what was, for some, a very difficult application process, now face having to go through a similar process again for PIP especially if they were awarded DLA for life.</p> <p>?) We would have to answer the same questions over and over again adding to the existing stress of our predicament.</p> <p>?) Information about a person's mobility or lack of.</p> <p>?) DLA has been important to getting a 'Blue badge' and freedom from paying Road Tax. Government agencies and councils should continue to talk to each other wherever possible so that a disabled person only needs to answer questions to one, not to lots of different organisations.</p> <p>?) There should be sensitivity to differing cultures and religious beliefs. There should be no age barriers to first claims. You can become disabled and need help at any age and it doesn't go away just because you reach pension age. Many people will now work beyond pension age and will need the same help with care and getting around as they might have done had they claimed before pension age. There are many fit and active pensioners, why should a pensioner with a disability not be given some help to enjoy an active and independent life too.</p> <p>3) Information about a person's mobility or lack of.</p>
ONLINE38	<p>1) The main barrier is funding. Having the appropriate assistance to achieve this is paramount. We must remember that trying to 'normalise' disabled people is not the answer, it is about assisting disabled people to reach their full potential, whatever that is. This of course requires appropriate funding to ensure carers, families and staff are trained and have resources to help disabled people reach their potential.</p> <p>If the government cuts DLA mobility to those in residential care the answer to this question would simply be a funding one as mobility needs would not be met.</p> <p>2) DLA mobility should remain the same for those in funded residential care as those in community. Without mobility needs being met we will closing the door on all those people in residential care. You must understand that residential care is not a choice. My son lives in a specialist epilepsy centre. Although he would be financially far better off at home here with us but would not receive the essential care and support to allow him to reach his full potential. At the moment as a 27 year old he receives a personal allowance of £22.30/week and DLA mobility (the home uses 70%). The home runs an amazing system of transport using residents mobility allowance, this actually allows those residents to fully</p>

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	<p>participate in society-something we are encouraging? How would he fund his mobility costs, clothes, toiletries etc from £22.30/week. Of course as his parents we top up out of our savings but won't be able to go on much longer. Without DLA mobility we will not be able to see him so often. The quality of all our lives will deteriorate.</p> <p>3) My son receives £22.30 /week and DLA mobility allowance of which he keeps 30%. As he lives in a specialist epilepsy centre he is unable to earn money but needs to be transported everywhere. The main extra costs he faces is that he cannot buy a specialist wheelchair/bike, new clothes, go on holiday, activity equipment for the garden, presents etc for Christmas, new furniture for his room, specialist leisure equipment, petrol to travel when he comes home to us (800 miles round trip without going out anywhere else)from this amount.</p> <p>5) Long term health conditions should mean an automatic entitlement irrespective of whether someone lives in community or residential care.</p> <p>8) The assessment should consider wheelchair use, need for car, need for assistance. In the home the assessment should consider all those aids and adaptations needed for the individual and their carers to remain safe and reduce risks.</p> <p>? ) Re: DLA Mobility Allowance in funded residential care</p> <p>I believe the government has misunderstood how this benefit is used.</p> <p>My 26 year old son, [REDACTED], has lived at [REDACTED] Centre for Epilepsy, a charitable specialist residential home, for 4 years. This is because he has a lifelong severely disabling condition called Lennox-Gastaut syndrome. The condition means he seizures several times every day, he has very limited mobility, autism and profound and multiple learning difficulties requiring 24 hour care from specialist nurses and care staff. It is important to do things [REDACTED] responds to because his life has very limited opportunities. [REDACTED] has very limited skills and is unable to occupy himself and suffers with repetitive behavioural problems. A drive out in the car will often alleviate potential problem behaviour.</p> <p>[REDACTED] receives £22.30 a week personal allowance (the same amount as an older person in residential care) and 30% of his mobility allowance, the remaining 70% paid to [REDACTED] towards transport costs. This clearly is not enough to cover the expenses of a young man. However [REDACTED] provide excellent and innovative care and support for [REDACTED] to live a fulfilling and independent life and we as his parents top up this allowance as necessary.</p> <p>[REDACTED]'s fees at [REDACTED] do not include transport costs, only his care and medical costs are covered by the fees charged.</p> <p>[REDACTED] use resident s DLA mobility allowance to provide an efficient and effective system of transport that allows staff to take [REDACTED] and other residents off site to socialise with his local community, to go shopping to enable him choice about food and clothes, to go on holiday, to go to the cinema, day trips to local events and to day time activities that cannot be provided on site for his particular needs and importantly for [REDACTED] to simply go for a drive (something he has always loved doing). At this time of year [REDACTED] and his housemates go to Pantomime, on his birthday he will again go into town with his housemates. All these activities the rest of us would manage without the need for specialised or expensive transport and of course we would have the means to pay for it. Other residents use the transport for other reasons. The other use of his mobility allowance is to visit us here in our family home in [REDACTED]. [REDACTED] comes home for a weekend once a month. The round trip for us to pick up, return him and take him out for drives whilst at home is approximately 800 miles. [REDACTED] helps with the cost by paying for petrol from the 30% DLA mobility allowance paid to him.</p> <p>As [REDACTED] do not receive funding for transport costs from the local authorities they depend solely on residents contributing their 70% DLA mobility allowance to use in the most beneficial way to ensure everyone has access and inclusion in the wider community, to have independence and choice and to have a life outside the care home. In other words doing the ordinary things we all take for granted. We have moved a long way in recent years to give disabled people, like my son, a sense of belonging and being accepted in the wider community. The Government have stated their commitment to equality and independence for disabled people, but his change will have a very negative impact on the</p>

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	<p>independence of people living in residential care. The residents at [REDACTED] are there because they need highly specialised care (which cannot be provided in the community), not because we want to shut them away never to be seen again. That attitude is in the past where it must remain. However, [REDACTED] does remain at risk of exclusion and removing this allowance will further discriminate against him. Without DLA mobility allowance there is a great risk of residents becoming institutionalised. Being in a residential setting does not equate to institutionalisation as long as successful homes like [REDACTED] can innovatively use residents DLA mobility allowance for purposes such as an effective transport system.</p> <p>If DLA mobility allowance is taken away, a charity such as [REDACTED] will not have the resources to provide the transport system that allows resident's the freedom, choice and independence we have legislated so hard for. We will not be able to see [REDACTED] as regularly as he will not be able to come back to the family home so frequently. When he did live at home he received benefits that covered his costs. Our expectation now is that at 26 he should be able to be independent of us, the same as our 25 year old daughter.</p> <p>The local authorities are trying to bring down costs to make savings so will not be in a position to entertain an increase in the fees to cover any loss of DLA mobility allowance for transport needs. Imagine the unfairness if even one local authority did agree to increase fees to cover transport. Would it be fair on those residents whose local authorities didn't agree an increase? Without having the funds to participate in everyday activities that non-disabled people like us take for granted [REDACTED] will not be able to lead a fulfilling life. I believe his behaviour will deteriorate and management of his needs will most likely require increased funding. So apart from the distress caused to [REDACTED] and us there will ultimately be an additional financial burden.</p> <p>Will you please ask Maria Miller, the Minister for Disabled People, to review her decision to remove DLA Mobility Allowance from residents in funded residential care? Will you also ask for evidence from [REDACTED] and the funding local authorities and re-assess the basis on which this decision has been made?</p>
ONLINE39	<p>1) Secure finance to pay for the additional costs involved in disabled people's lives. Enough quality PAs to assist disabled people effectively from a position of enabling rather than helping. Discrimination from non-disabled people making assumptions about disabled people's intelligence and abilities. There is neither carrot nor stick to challenge this. Physical access is still a huge problem, travelling is like a NATO exercise and can go pear-shaped easily.</p> <p>2) The focus on DLA being available for the additional costs incurred by living as a disabled person rather than paying for statutory services and healthcare. This maintains DLA's use of the Social Model of disability rather than sliding back to relying on the Medical Model.</p> <p>3) Equipment, utilities, clothing, care, transport, communication, medication.</p> <p>4) I believe limiting the components to two will squeeze more disabled people from being able to access assistance. The advantage of a greater number of components is that it is more flexible to a wider range of impairments and needs. I can predict fewer people passing the threshold and those who may have fitted in between the two will be left in the lower component, ensuring the benefit will meet fewer of their care and independent living needs.</p> <p>5) All claims should be based on the needs and circumstances of the individual applying. Disabled people respond differently to their individual impairments. There are many health conditions and impairments with a varied impact on the individual, I do not believe it is possible to compartmentalise people and how they live their lives by the impairment / health condition they are diagnosed with. Further, there are a large number of people living with undiagnosed conditions; how will a fixed rigid system respond to these people?</p> <p>6) At the moment, we prioritise them according to income and ability to shout the loudest; this is wrong. It is almost impossible to put my finger on specific activities essential for everyday life. There are physical activities like getting up and dressed, leaving the house once a day. Equally essential are participating in your community, having a social life.</p> <p>7) I can only think that statements from friends, PAs / carers and family members who can confirm the difficulty an individual is living with. This would also help people like myself who experience significant short-term memory loss.</p>

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	<p>8) Yes, an assessment should take into consideration the aids and adaptations disabled people use. It must be recognised that few of these are actually available free; disabled people will need to fund them and an assessment needs to remember this. I don't agree that an assessment should take into consideration aids and adaptations disabled people do not yet have. Thresholds for assistance with independent living aids continue to get higher and higher excluding disabled people from support equipment.</p> <p>9) The current form is 28 pages long (if I remember rightly) and explores all the things a disabled person can't do. A number of questions are duplicated, perhaps more attention to the questions might shorten the agony. Someone helped me to complete mine which was an amazing help. I have found the new online form a good aid, what I have found, however, is a large number of disabled people don't have access to the internet. This should be explored as it could provide the information in a format which can be adapted to meet a wide range of print disabled people's needs in a cheap and easy way.</p> <p>10) I believe there needs to be a combination of medical and social evidence to adequately attempt to identify a disabled person's needs. I believe medical statements particularly from GP's and OT's of use but also information from community centres, friends and supporters / carers / PA's is equally important.</p> <p>11) There will be problems with meeting different communication needs, managing stress, access and identifying the needs of variable conditions. Managed appropriately, I believe these issues may be overcome. I would need to be reassured that the interviewing person was actually a trained medical professional and not an administrator with 6 weeks training. I would have a concern for individuals with mental ill-health issues for whom the distress of a face-to-face interview may be too much.</p> <p>12) I believe reviews are necessary as people's needs change. My concern would be the frequency of such reviews. I have a progressive neurodegenerative condition and yet was reviewed initially every 6 months; I believe this to be unreasonable and, with support, was able to convince DWP of this. I believe there should be criteria to guide the regularity of reviews but that they should not be cast in stone allowing for individual's different experiences of disability and impairment. To a certain degree, diagnosis will guide the regularity and type of review. I also believe it to be necessary to take information from carers / PAs, family and friends. I would suggest likelihood of recovery at some point in the future may inform the review regularity.</p> <p>13) It is my experience that most people do not keep the Department informed of changes in their condition out of fear. Currently, I believe there is little trust between the Department and disabled people. The current rhetoric in the media about disabled people being workless layabouts taking money from the honest taxpayer does not help. I was an honest taxpayer before becoming ill! Since becoming disabled I have had contact with a number of disabled people; many of whom have expressed fear over losing the little money they have that just keeps their heads above water. Most have examples of disablism they have experienced in the community. I believe some committed, positive work needs to be done to reassure disabled people that reviews are to help make sure their needs are met rather than prove to the Daily Mail that few disabled people qualify for financial assistance.</p> <p>?) Yes, this information would be valuable. The Department needs to ensure that adequate time scales are available for disabled people to be able to absorb and understand this information. Ideally, the information needs to be available in a range of formats and electronically. I would suggest reviewing the language used too as it gets a bit complex in places and consideration needs to be made for learning disabled people as well as those who find either medication or illness has an impact on their comprehension.</p> <p>?) I fail to understand why the system is to create a stick to bash the minority who for some reason are unable to participate! Should not a positive action of some sort be available for those who do access this information? I strongly believe that moves towards further punishment of disabled people is wrong. We already experience significant discrimination every day as well as having to manage an impairment as well as having to fight for the right medical and social care. Please consider that some disabled people do not access additional information / advice and support because they simply have no energy left.</p> <p>?) Currently some disabled people are in receipt of passport benefits which enable them to access some money for some aids and adaptations. Local authorities used to provide a number of small aids - which has stopped now in this time of cutbacks. Major adaptations were funded through the Disabled Facilities Grant although that seems almost impossible now the threshold to access it has changed. My husband works so we were naturally exempt from any form of financial assistance and were left to try and find over £8000 for</p>

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	<p>the adaptations to our Housing Association home. He does not earn a fortune - not £20000 - so I was left to try and fundraise the sum from charities and trusts. I was offered no support or advice on how to raise this sum. Equally, my mother also needed adaptations and has not been successful in raising the £3500 that she was told she and my dad had to find. There definitely needs to be some form of assistance - fundraising from charities is going to become more scarce as pressure increases on their resources due to Local Authorities and the NHS being able to provide less and less support financial or otherwise. My fear is that using the Personal Independence Payment for this purpose may mean living without another form of essential support - it's not new money, it's robbing Peter to pay Paul.</p> <p>?) It is essential to remember that assessment is going to need to be more frequent and even more focussed on what the child could do as the opportunities are greater. It is equally important to recognise the additional strain on families who find themselves unsupported and alone dealing with fighting for their child's needs as well as the guilt associated with being a parent of a disabled child. Flexibility needs to be considered with payments for support and childminding. Often parents are unable to find a childminder or carer for their child due to their challenging and often complex needs. It needs to be recognised that for some parents the only option is to rely on family members; as such, it needs to be acceptable for payments for care and support to be made to family members.</p> <p>?) I have found DLA invaluable in enabling me to access other support services. I have found staff at the DWP helpful in providing up to date proof of my eligibility. I believe there is opportunity for DLA to be further linked up to make it easier to access local services; I think greater communication with Local Authorities will facilitate this. I have a concern that I really hope will be recognised. The great risk of tying further support services to DLA eligibility is that there will be people who for whatever reason are not considered disabled enough yet still require support. The risk of linking too much to DLA eligibility is that there could be a raft of people who will be denied even more support services and assistance.</p> <p>?) I think it will mean that a larger number of disabled people may have access to the support services available. There is a huge risk that we would end up with a system similar to Income Support being a passport benefit. This has meant that I have been immediately refused services I need because my husband earns just £100's of pounds a year too much.</p>
ONLINE40	<p>1) Low income due to increased costs associated with disability and perhaps limitations in employment. Poor access, prejudice and ignorance. Inability to afford equipment or treatment due to low income possibly exacerbating condition and certainly trapping the disabled in the home or left reliant on others.</p> <p>2) The link to Motability should stay. It has been a godsend for me to have a vehicle that I can get in and out of and drive to enable me to get to work.</p> <p>3) Medication/prescription costs  Costs from secondary illnesses or injuries caused or exacerbated by illness/disability (falls, pneumonia etc...)  Equipment hire and purchase such as scooters, stair lifts, gadgets to help peeling veg or opening cans...  Transportation either by taxi or public transport or own vehicle. Suitable vehicle, vehicle adjustments and adaptations  Hospital and doctor appointment parking costs</p> <p>4) Possibly will make it easier to administer but I feel understanding will be wrapped up in the assessment process and eligibility criteria.  The two rates are likely to be used to reduce the amount of benefit people get. I imagine most who qualify will be given the lower rate and higher will be almost unattainable for most.</p> <p>5) I think if it is clear, as in the renal dialysis example, that someone is severely impaired by their condition then they should retain automatic eligibility. Why cause those people further stress by assessing them when they are so obviously affected?</p> <p>7) This is a difficult one. The current form asks for frequency for each section as well as severity etc. These people are often not able to say with any accuracy how I will be one hour to the next, let alone tell how often in a week they will be very bad. This means the current questions are not helpful for these people.  Also, with variable and fluctuating conditions, they can often be helped by the benefits of having DLA. This means that perhaps the illness is improved by these benefits whilst they are available to them but if they are removed because assessment shows them to no</p>

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	<p>longer qualify they will deteriorate.</p> <p>I think the key for these people is that the assessments ARE based on the individual and not trying to squeeze everyone through the same template. Just because an individual can walk and work etc on some days does not mean they are always so well. Also, they are very unlikely to be seen by others when they are really bad so people will see them as well and able when in fact, half the week they are bedbound.</p> <p>It is vital to assess these people individually because they cannot answer with a simple yes or no and they certainly cannot quantify their illness.</p>
ONLINE41	<p>1) Exclusion due to disability that enables them to meet, interact and socialise with the public, friends and family. A regular 'allowance' helps to purchase aids like wheelchairs, mobility scooters and adapted vehicles to move around 'outside' and stair-lifts indoors. It is very important that a disabled person can still access shops, the cinema and theatre etc to avoid loneliness.</p> <p>1) Mostly being able to access forms of mobility to get from A to B. Also care requirements with regard to personal hygiene, dressing and feeding oneself.</p> <p>2) The higher amount of payment for care and mobility should stay the same. Once assessed by a doctor, those with degenerative conditions that are in receipt of both the highest rates need only be assessed every few years.</p> <p>Overall, those most disabled should not be 'worse off' under PIP.</p> <p>2) The Higher, Middle and Lower payments should stay the same.</p> <p>3) All forms of mobility for those almost unable/unable to walk attract the greatest cost. Motorised wheelchairs, mobility scooters and adapted vehicles being the most costly. Stair lifts for the home are also very expensive.</p> <p>3) Care, mobility and adapting the home are the main costs.</p> <p>?) To stop bureaucracy and duplication, it would be a good thing for agencies to share information. As I do not know all the agencies I can not state which ones could access information.</p> <p>4) Having only two components will not allow the disabled who have progressive illness/disease to receive the correct level of support.</p> <p>4) Two rates will make it easier to administer.</p> <p>However, for those with degenerative illnesses/diseases, having only two rates will not reflect gradual disablement as does the lower, middle and higher rates. They will be kept on a lower rate for much longer after their disability has advanced.</p> <p>5) All should be based on the needs of each individual applying. Many long term conditions/diseases vary considerably.</p> <p>6) To be able to wash/bath/shower and dress oneself and to be able to make a hot drink, cook a simple meal are the activities of daily living. Also to be able to feed oneself. If the disabled person can not do any of these things, they require the most support just to live.</p> <p>7) It must be assumed that if the applicant USUALLY is unable to carry out a function, they should be assessed as NEVER being able to carry out that function.</p> <p>8) No - the assessment should not take into account aids and adaptations used.</p> <p>I would not be able to get my husband into a car to visit hospitals, doctors etc without the aid of a wheelchair. It should not mean that because the wheelchair makes him mobile that he should be financially penalised.</p> <p>9) The claim form is very repetitive. There is no need to keep asking the same question over and over.</p> <p>By using 'bullet points' in the first instance. A slightly more in depth version can follow.</p> <p>10) Their hospital consultant will give the most in-depth analysis of their condition followed by their GP. I keep all written reports from consultants regarding my husband's latest visit, along with hospital appointment letters. These reports etc should be used as evidence.</p> <p>11) Along with other disabilities, my husband has Parkinson's disease. His speech has deteriorated over the years to such an extent that even I find it difficult to understand him. I would have to be present to speak for him. He also</p> <p>12) The frequency of reviews should be decided on individual applicants. Letters/reports from their consultants etc detailing their declining health affecting their disability should be used in the first instance. If necessary face to face interviews/reviews.</p> <p>13) The only way is to have frequent reviews for cases that are deemed might improve. Those with degenerative illnesses/disease ALREADY in receipt of the highest rates for mobility and care should not be reassessed regularly - only every few years.</p> <p>14) Bullet Points listing ways the allowance may be used to enhance a person's life would</p>

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	<p>be informative.</p> <p>15) Clear advice again in the form of Bullet Points and maybe television advertising outlining the benefits of how PIP can enhance a disabled persons life. Each applicant would need a full medical assessment to stop false claimants applying.</p> <p>16) For my husband,DLA payments are used to part-pay for adaptations to the home such as converting the bathroom to a wet-room with disabled toilet, a stair-lifts to access bedroom/wet-room, adaption of the downstairs WC for disabled access and the purchase of a mobility scooter; all of which would not have come about without the receipt of DLA. My husband would have been confined to living downstairs without access to proper bathing/toilet facilities. It no doubt would have resulted in him going into care. There should be an option for one-off payments of PIP for those who need it.</p> <p>17) Not sure how to answer this.</p> <p>?) Can't see there will be any undue impact on any equality group, as all should be treated equally.</p> <p>?) We do not use DLA for a Motability vehicle but have funded our own vehicle. (I worked out that over several years it was cheaper to finance our own vehicle). My husband does use the Blue Badge Scheme which has been a lifeline to have a wide parking space to bring a wheelchair to the door of a vehicle. I am sure these passporting arrangements help other disabled people obtain services and entitlements with ease.</p> <p>?) It would mean a 'minefield' of form filling-in and put the disabled off trying to apply.</p>
ONLINE42	<p>1) Being disabled clearly costs more, especially when people need specialist equipment (not all of which is now provided through social or health services) and where transport costs are higher - for example, someone with a mobility impairment may not be able to walk to their nearest bus stop or station; in rural areas, there will be a dearth of public transport, so much greater reliance on either owning a car or on hiring taxis. This has an impact on whether people can prepare for, attain, and maintain employment. Where people have used the mobility component to purchase vehicles, they have been able to be independent, and we know of many who hold down responsible jobs and don't claim any other benefit.</p> <p>People who appear to be fit and healthy may face social exclusion because of sensory impairment. Deaf people are isolated in most social situations, the more so if the hearing loss is acquired. Extra financial costs are incurred where specialist technology is used to reduce some of the barriers, or where human aids to communication enable the individual to take part in an activity that they would not otherwise be able to access.</p> <p>Many disabled people need others to help them to do things such as keeping clean, getting dressed, preparing food and drink, keeping their home in order, getting around, etc.</p> <p>People with more hidden disabilities, such as learning difficulties, may rely on someone to help them to understand their mail - bills etc - and to manage daily living tasks.</p> <p>Increasingly, people are found not eligible for social services support (due to FACS) and so access to DLA for care is crucial.</p> <p>Other barriers include people's attitude towards disability - there is still a lot of prejudice. Our students still find it more difficult than non disabled people to get and sustain jobs. Our students with learning difficulties experience harassment by school children when out and about, are frequently taken advantage of by shopkeepers and other members of the public, and our students with mental health problems often need support from another person to manage their daily living needs.</p> <p>People who have health conditions that fluctuate are often in a very difficult situation. Their condition may make it much harder for them to regularly attend courses or hold down a job. Fluctuating conditions must be recognised when assessing for the new benefit.</p> <p>That being said, people's expectations of themselves can sometimes be a huge barrier, and we think it is important to support people in building up their skills and confidence and developing strategies to manage an independent life. Many people do so very successfully, but the extra financial help is usually crucial to them doing so.</p> <p>2) We are concerned about the extension of the qualifying period to 6 months, because we think that this could leave some people in a vulnerable position, one that could render them more socially isolated. We would not want to see people lose jobs or homes through delay in accessing DLA. Given the time taken to process claims, they could be waiting for the best part of a year.</p> <p>Having said that, we also believe that the benefit should be targeted at people with enduring conditions.</p>

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	<p>We believe that the new benefit should remain distinct from any other assessments or criteria, including social care assessments.</p> <p>3) Extra costs are many and varied, and depend on the individual's circumstances. For example, transport costs will be much higher for the person with a mobility impairment or learning difficulty in a rural area, as opposed to in cities that have progressed in making public transport accessible.</p> <p>Another variable will be around equipment: the more technologically complex the equipment that enables the person to maintain maximum levels of independence, the more costs are incurred. Some, but not all of these may be covered through Access to Work, but this will not include adaptations in the home and won't cover, for example, the cost of a motorised scooter or adapted car.</p> <p>Some people will have expenses related to the support they get from another person. Again, this could take any number of forms from providing personal care, to providing communication support, to enabling the person to travel out of doors, to helping someone to read their mail and respond, and much much more. For people with enduring mental health issues, they may have the added expense of someone to keep an eye on them to make sure they're safe or to ensure that they maintain some level of social contact. For many people who claim DLA, having someone to keep an eye on them is crucial. They may be prone to falling, or having seizures, or behaving, through no fault of their own, in ways that present a risk to themselves or others.</p> <p>Many people will need to have specialist diets in order to stay healthy, and this can incur additional costs.</p> <p>Essentially, the extra costs cannot be listed because they are specific to each individual and dependent upon their particular personal, social, and geographical circumstances. Therefore the examples above are simply examples and not a definitive list.</p>
ONLINE43	<p>1) Availability of quality support work more than just basic care this support if to find employment access community supports and promote independence good support helps individuals find their place in the community and helps challenge community barriers to inclusion</p> <p>3) It is not only the cost for the person but also the support provider these are varying e.g. the person going to college may require someone to assist them to and from college but not while they are there I would be an additional cost for 2 people to travel and the additional journey for the supported home and then back. Paying for two tickets to events as individuals need support in the community, Purchasing of equipment that meets a specific need that enhances life not only meets basic needs e.g. seating beds better equipped wheelchairs etc</p> <p>5) If individuals have very complex disabilities or health needs and there will be a need for high levels of support for life then this should have an automatic entitlement and reviews should be straight forward</p> <p>6) personal care needs are essential however social needs to prevent isolation and prevention of mental health issues are also vital if someone can't get out each day due to their condition then this is an issue how full can their lives be I hear professionals say but I don't want to go out in the evening when they forget that they are out every day working shopping picking up the kids etc The more you do in the community the more confident you feel to do more The untapped resource in volunteering is disabled people</p> <p>7) If someone has a fluctuating condition they don't know when it will be better however this may require having an award for a set period of time the disabled person will be available for reassessment but will the assessor ??? This is often the problem that no one is available within time frames due to work load</p> <p>9) If everyone is to be treated individually you can't use tick lists or questions like how many times etc A full explanation should be asked for and someone to write out the form in need explaining and this confirmed by the person doing the support as most people are unwilling to declare just how much is done for them by others they find it difficult giving every detail of their dependence</p> <p>11) home visits should be sought this would give a clearer view and an assessment may also be available to get better aids and adaptations into the home for greater independence this would also ensure that all was being done to promote independence where a local OT or health provider may not have provided due to financial restrictions I know of a family where the father was still lifting his adult son in and out of the bath until he hurt his back and then help was offered some folk don't want the money they want an easier life.</p>

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	<p>12) some people with very complex need will have significant support needs for all there lives and the need for individual resourses to meet their needs not just bog standard equipment and these will be needed for the rest of their lives and noone would expect diffrently these should have an extended review time but should still be review to see if their are advancements it support that they could use</p> <p>14) an over all view of benifits and benifits checking too much working in isolation of departments which is not easy to understand i wider veiw of things that can help people be more independant not just money motability aids adaptations and advice on how this can be paid for help with maintaining households heating etc how to find aproprate specific support, empoyment, training and advocacy</p> <p>15) yes people dont want to claim they need help from others however when they get it it drastically improves their life experiance but this must be person centred not preaching</p> <p>16) yes</p> <p>? ) yes looking at the over all entitlement including making the information about what you get easier to understand I have seen benifit award letter where you have no idea what has been awarded because there are so many details about you get and disregards and it is very difficult for individuals with learning disabilities and their workers to work out if it is correct</p>
ONLINE44	<p>1) Isolation and inability to integrate</p> <p>2) The level of funding should account for the fact that it can be restricting income for individuals as well. It is incorrect to assume that a disabled person hgas a cleaner as a luxury rather than a neccessity for example. The current system was fair in its assessment particularly when medical professionals that knew the patient were acknowledged</p> <p>4) Less accuracy and broader issues for changes of circumstances partcularly where temporary</p> <p>5) Some progressive illnesses should be included which are not and "terminal" being used as a fixed 6 months is ridiculous as someone having treament has to assume they will get better</p> <p>6) The ability to remain as normal as possible and mix in a normal way...normally impossible and unattainable unless non progressive.</p> <p>7) The patients own clinical assessment teams rather than employ an outside illjudged opinion computer driven.</p> <p>8) Adaptations which are essential to improve the individuals way of life and give better quality of life whether easily obtained or not. The majority of adaptations are bought personally and retained where benefits are apparent. The adaptations should be readily accep;ted as being what someone diagnosed with a disability needs to use. In other words walking sticks are a simple aid whereas a wheelchair s more of a walking aid etc etc</p> <p>9) Simplify and request more info from medical teams treating them or past history</p> <p>10) Patients own Consultants and medical providers past and present</p> <p>11) Needs professionals equal or better than the patients treating consultants in all fields that are relevant. In my case that is four different areas and some areas conflict with others. Ok in stable cases to assess that way but not otherwise</p> <p>12) Reviews only need to be caried out at short frequencies with varying or conditions that are known to improve. Where ill health and disability are a poor diagnosis regular reviews are an extra stress and unecessary burden on the patient. It depends purely on the conditions involved but those who need to be left alone should be., If someone is potentially terminally ill outside the six months all reviews should be carried out with theirown medical teams and not an outsider</p> <p>13) Increase the fraud detection side of DWP</p> <p>? ) AS of now where any claim can be reviewed at any time</p> <p>? ) difficulty reading chapter 3</p> <p>? ) Full coear definition</p> <p>? ) Hope that they are better though out than the ESA and ESA/ICB changeovers and are safely cost effective rather than Political motivated to no point</p> <p>? ) I accessed most of my other entitlements through DLA paricularly travel related and also it has replaced the disabled register of the past for other organisations</p> <p>? ) Maybe a one off cost but paidback over a period of time from future payments guaranteed by other means if benefit is withdrawn</p> <p>? ) No comments no ideas</p> <p>? ) On past Gov record haste rather than speed and look at carefully. it needs to ensure</p>

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	<p>that there are not people trapped between Gov and DWP interpretation leaving many in financial difficulty whilst drawn out appeals and tribunals hope that the errors will disappear ?) Other systems would need to be in place</p>
ONLINE45	<p>1) The number one thing preventing disabled people participating etc is *their own disabilities*. Without adequate treatment and support for the disabilities, nothing else will be of any use. Also society's attitude towards those with disabilities is, particularly of late (thanks to the media attention on the hugely overrated and inaccurate amounts of benefit fraud) openly hostile and suspicious and paranoid. This is actively detrimental. Any disabled person--and far and away the majority of those on benefits *do* need them in order to function and are *not* committing any sort of fraud, but instead help they desperately require--is going to feel worse if they are automatically assumed to be a thief and liar, and for many types of disability that negative attitude will actively and physically manifest as further disability. Even an entirely healthy person has a difficult time managing in a society where the worst is assumed of them, and the disabled live with this constantly. Above all, we need to treat disabled people as people who *can* be an active and useful part of society, *not* dismiss them as scroungers.</p> <p>3) This varies hugely depending on the manner of the disability in question. For some it's medical, medications or counselling or doctor access that's required in order for them to stay alive, to say nothing of function. For others the main difficulty is transportation, anything from a taxi to get to the store to installing equipment in the house to help them get up and down stairs. For some it's the whole shebang, requiring people to actually be in the house and help them constantly with little tasks most take for granted, such as washing hair and brushing teeth and making tea and *drinking* the tea. There is no simple answer to this question.</p> <p>4) I can't say it's going to make things easier to understand and administer given that I don't yet understand how it's to work. So offhand I'd say no, it doesn't look promising. A major disadvantage of having two rates per component is determining who merits one rate vs another. It's putting suffering on a sliding scale, which seems bound to backfire.</p> <p>5) This is hard. Again, suffering on a sliding scale; I do think some health conditions and impairments should mean an automatic entitlement, but I'm sure my opinion about which will differ from someone else's, and so on and so on. So while I'm for the idea I can see that it would be hugely difficult to implement. There are some things I imagine most people would agree on--for example, if a person is physically incapable of getting out of bed, ever--but finding a place to draw the line seems impossible.</p> <p>6) Sanitary needs. Eating. Bathing. Breathing. Those and the like are needed to survive, anyway. For a full and active life, a person needs social interaction for affection, a vocation for personal validation, and a hobby for relaxation. Note: even those incapable of "work" as most define it (a job for pay) can have a vocation, whether volunteer work or arts &amp; crafts or who knows, there are a myriad of possibilities. So I would argue that another important task of those who provide benefits is providing access to people who can help a person find a vocation.</p> <p>8) No, because there is no guarantee that a person will continue to have them (if already possessed) or be eligible to get them (if not yet in possession). It's all very well to say "Ah, that's easy to accomplish, it doesn't need to be my problem." For the disabled person, it probably is NOT easy--or even if it is possible at the moment, it might not remain so.</p> <p>9) Above all, be clear and consistent. Use simple language wherever possible and beware of jargon. Even the most erudite person can be overwhelmed, especially when under significant stress, as it can be assumed anyone applying for benefits must be.</p> <p>10) A medical history. A clear assessment of ability can only be determined over time. A set of tests administered on one day may find completely different results from a the same set administered on a different day, particularly for those with pain levels that fluctuate. A GP or ideally several GPs are best to provide a medical history, though documentation from those associated with the claimant (if possible/available) should also be considered, i.e. family, previous employers/co-workers, even friends. Clearly a professional viewpoint is best but don't undervalue the information a person's social circle can provide, they've been watching the claimant more closely and for more time than you possibly can. True, it's possible to fake such documentation, which is why it would be best used in conjunction with more official things, but it still has value.</p> <p>11) Potential difficulties first: the person might be distrustful of healthcare professionals in general depending on their past history; it would be vital to get professionals who will not</p>

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	<p>be dismissive but instead will be approachable and informed and there to help rather than hinder. Benefits...if the professional can help determine what sort of assistance the claimant needs, that would be good. I'm wary of such a consultation being a lie-detector test to weed out the fraudulent, however. There should not be an assumption from the start that the claimant is not really disabled.</p> <p>As for inappropriate circumstances...I'd certainly think it necessary to let the claimant have a chance to choose the gender of the professional in question, and if possible to give them a choice of location so that they have a "safe" option. But no, I cannot think when it would be inappropriate to have a professional consultation be required, provided that the professional in question is aware of a patient's medical history and will take them seriously.</p> <p>12) Different types of review seem a good idea, frankly. Some disabilities improve over time, and some simply do not; for the latter there doesn't seem any point in having frequent reviews. Why waste everyone's time (and therefore money) on a situation that is known and stable?</p> <p>13) Be encouraging and informative about its importance. There are many reasons why changes might not be reported, and while some are just plain forgetfulness or "I didn't realize it was important", some are going to be panic/paralysis, or inability to cope with new and more negative circumstances, or even in the case of a positive change the fear that any change will result in the benefits being taken away (even if they might not be). When you've been unbalanced for a long time and finally found a stable position it's hard to believe that it's not temporary, and you don't want to do anything that might risk unbalancing it again. Change is scary.</p> <p>?) Children are COMPLETELY helpless and at the mercy of adults. This cannot be understated. In many cases they cannot speak up for themselves or explain what's wrong; they don't have the knowledge or ability or skill to do so.</p> <p>That said, I think the same is true for the quite elderly, and it's as vital that this not be forgotten for them either.</p> <p>?) Hard to say. Having access to advice and support would be welcome to many, but having it be a requirement creates another hoop they'd need to jump through, and they already need to jump through quite a lot of hoops and it gets overwhelming and terrifying and just plain confusing. I would say having them be available but not obligatory would be best--so long as it's clear that they are available but not obligatory.</p> <p>?) Yes, there should be. Disabled people currently fund their adaptations in a variety of ways depending on their circumstances, there is no set answer; those who are able to work use their pay, some are dependent on help from friends or family or saving, and some just do without. But I can easily imagine situations where a disabled person might not need a regular number of benefits but a one-off payment. For example, to buy an electric bicycle which would enable them to commute to work without getting exhausted, which would allow them to keep working, which is good for everyone.</p>
ONLINE46	<p>1) HEALTH anti social behaviour, hate crime, lack of income VULNERABILITY to dangers some need supervision and lack communication skills low self esteem no pavements, steep hills lack of facilities in their communities from council cutbacks increased fees or closures due to the recession!</p> <p>2) the right to tribunal, challenge of decision right to appeals must remain</p> <p>3) can i just ask if a "key activity" includes being able to self feed and self toilet? please dont have an image of a pleasant stroll in the park main extra costs: specialist clothing, wigs, equipment that is no longer funded by nhs or occupational therapists due to council cutbacks in this recession. petrol and transport costs including car parking tickets and car parking fines whilst waiting at hospitals miles away from where they live.having to rely upon another driver just because they can walk in excess of 200metres but perhaps experience agony after 500metres. staying at home can be costly with heating bills in these winters and tv licences just to stop boredom. DAMAGE we have had in excess of £3000 costs to experience to replace items that have (unintentionally) been chewed or binned or broken or pulled off of their mounts from our son with severe learning difficulties. once replaced it WIII happen again you know!</p> <p>4) no</p>

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	<p>if these two rates are equivalent to "mild" and "severe" this could be tricky for the extremely complicated unique quirky individuals who may be able to be "mild" on some activities and "severe" in others at the same time, I fear one may contradict the other</p> <p>5) every disabled person is an individual one and I think it is fair to be treated as an individual.</p> <p>when certain health conditions and medical occurrences prevent the person from functioning as a human being should ordinarily function then yes certain conditions should still be automatically acknowledged and awarded</p> <p>an example is : tube feeding; unable to toilet without medical intervention; an automatic award for the sheer dysfunctional existence within one's body.</p> <p>8) if a non disabled person exists without aids to be a non disabled person then all aids and adaptations used by disabled must be taken into account whether used or not assessors to understand the potential impact of psychological acceptance/denial of their disability or hope of a recovery. so everything must be taken into account</p> <p>10) every medical professional has their own theory or perception of the case!!!! unfortunately they are not always correct and second and third opinions usually sought!!!!</p> <p>I would be disgusted to describe my son's disability in one hour to a stranger. A member of a team of multi disciplinary health care/staff who know the person and their presenting problems and has seen them within past 3 months and have not discharged them to comply with government targets but are brave to keep open ended appointments clearly work with and for their patients.</p> <p>an appointed therapist DOES NOT WORK FOR THE PATIENT and is likely to form working hypothesis only.</p> <p>11) social and communication difficulties with severe mental impairment! wouldn't work for mine!</p> <p>but, I do agree that face to face may demonstrate and evidence an application</p> <p>12) do you know how many reviews are carried out already from social care etc?! another review!</p> <p>I still agree that the responsibility lies within the individual and if there are changes DLA will not know until reported.</p> <p>perhaps the earlier question 5 should determine when there is a review or not. one must remember how long NHS take to see patients, refer patients, have meetings etc or courses of treatments and therapies aiming for more independence take</p> <p>13) well if they don't report it because they think they are about to lose something financially thus making them dishonest people.</p> <p>incentivise them with a "healing/recovery/target achieved? bonus as a one off closure payment</p> <p>this won't apply to all</p> <p>14) they need to know that everything stated in 36 takes one heck of a lot of time. to request, be denied, request again, and that it is all a money saving GAME with some departments. ALL our FIRST requests for equipment "got lost" whoops...pattern identified so their aids and adaptations are more likely to take even longer with government cut backs and loss of council staff and over worked staff from social care perhaps even relying upon UNPAID voluntary Bankers? whoops Volunteers in the community</p> <p>15) internet at home</p> <p>"minority of claimants" not take action? are these the ones too disabled, sick or poorly</p> <p>16) not when the disability is a non chosen one</p> <p>pardon me don't want to offend anyone if I haven't already done so</p> <p>but if the disability is as a result of self harm/self inflicted/addiction/ stupidity during an incident or more that one has not insured their self for then YES why not charge a fee.</p> <p>if disabled from birth or disease etc through no choice then NO disability is not a choice for these people</p> <p>17) risk of harm</p> <p>vulnerability</p> <p>risk of abandonment/foster carers</p> <p>future mental health problems</p> <p>supervision</p> <p>the Childrens Act, Law</p> <p>European Law - Right To Education</p>

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	<p>every child matters frameworks            Parents and Carers are their permanent Teachers, punching bags, nurses, voices for their rights, house maids, chefs, drivers, so much more than an adult.            try not to interfere with education spending there is the European law for the right to education.            their child siblings have a right to a peaceful life too under EHR...</p>
ONLINE47	<p>1) objective assessments often fail to take the subtleties of an individual's needs into account.            For example my son can and does hold lucid, intelligent conversations but his ability to misinterpret and misunderstand means that he is at risk and needs mediation to enable him to function effectively in spite of his intelligence.            He has no official visual or physical impairment and has perfect vision in the physical sense yet his visual processing is so impaired that he cannot cross a road, cannot remember a route and cannot see a person's face which means he cannot go out without a carer.            I am very worried that the new rules will narrow the definitions of disability and make it impossible for someone like my son to get the support he needs</p>
ONLINE48	<p>1) The first barrier that we have experienced is that anyone with a disability is often considered as being inferior and incapable of speaking on their own behalf regardless of the type of disability. My wife has a physical disability affecting her mobility but is normal in all other respects. When using her wheelchair she is often ignored or patronised in ways which do not occur if she is using her other aids and standing.            There are still some physical access barriers to be overcome. Provision of ramps and lifts has improved over the last 10 years but we still encounter problems with stairs in some places.            Access to information and support is a considerable problem especially when someone becomes disabled suddenly. Trying to get access to this when coping with the immediate aftermath of a serious illness or accident is extremely difficult. There are many agencies who can provide assistance, mostly government departments, but there are few 'one stop shops' where all of them can be contacted. Often NHS facilities are the first point at which disability is identified but in our experience there was no linkage from the hospital to social services or the DWP. We had to approach all of them separately. If you want to improve the lives of those who will be in need of DLA or the future PIP you should be seeking to introduce an assessment process that starts as soon as possible long term disability is identified and links in all of the potential support agencies. This should be a key principle of your reform.            2) I agree with points that are covered in paragraphs 8 to 12 of Chapter 2. What I cannot agree with is the proposal later in the paper that there should be a new qualifying period of what appears to be at least 6 months before entitlement begins. The money from DLA is important to provide funding for getting about, getting support either in carer/assistance staff and for the purchase of aids which are not covered by NHS or social service funding. These things are needed most in the immediate aftermath of a disability inducing event. My experience is of caring for a wife who suffered a stroke and we needed most support in the months immediately after the stroke not 6 months later.            Coupled with this is the access to other support which is 'passported', as is described later in the chapter. Key to these are the rapid issue of 'Blue badges' to ease the getting around difficulties especially as this is the stage where patients are likely to have to go to hospital for further treatment on an almost daily basis after a stroke, for example. Also important is rapid access to Carers/Attendance Allowances which are crucial in getting the high level of support needed in the period straight after such a life changing event. Under the new system there will be plenty of scope for adjusting these at the periodic reviews.            3) In the first instance, immediately after a disability inducing event, aids to mobility were a priority although some of these were NHS provided. Hand and grab rails around the house were important and not funded centrally. Alterations to provide accessible bathing arrangements were our next priority. The other tranche of aids were those required to enable the safe preparation of food and drink and to facilitate cooking, serving and consuming them. Both of these last 2 aspects were funded by DLA.            Medical costs went up immediately as the range of drugs needed rose rapidly. Even the use of a pre-payment card is much more expensive than my wife's pre-stroke usage. DLA covered this</p>

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	<p>Travel costs rose as my wife was unable to travel such long distances without tiring, nor could we share driving for over a year. Trips required us to spend more nights away in hotels where the journey was more than a few hours or we could not get to bedrooms in the houses we were visiting. DLA helped us with these costs as well.</p> <p>4) Without seeing the detail of the new assessment it is difficult to judge whether the new 2 level system will be easier to understand and administer. It could be argued that with the use of an objective assessment you could still use the 3 tier system but be more confident that it was being applied appropriately. It may appear that 2 tiers will be easier to administer but it is not at all clear that it will better reflect individual needs. Logically 3 tiers should be better tailored to needs.</p> <p>I could foresee a considerable number of existing claimants disputing their rating in the new system if they feel they are being deprived of funding they have received for a long time under the previous regime.</p> <p>5) This question links to the proposal to introduce a qualifying period for DLA. All of the events in Annex 1 require the support immediately. It cannot be acceptable to create a delay in delivering the support the claimants need to allow assessment before giving an entitlement. It could be argued that there is scope for increasing the range of conditions covered in this way, subject to medical evidence, to ensure that funds are made available to claimants in their hour of need not 6 months down the line. Periodic reviews then give the scope to adjust levels of support as necessary at a later date.</p> <p>6) I agree with the principle of a broader assessment and the activities suggested in paragraph 25 as a start point. It should not be forgotten that many DLA recipients want to be able to get out and about for both pleasure and work. These aspects will need to be considered in designing the assessment. It is difficult to provide more useful comment with seeing more details of the proposal in due course</p> <p>7) Why not ask about how things are on a good day and a bad day. Seasonal changes also occur in some cases so why not pose the simple question of whether there are such differences during the assessment.</p> <p>8) If you want a level playing field for all claimants you will need to establish a baseline of capability without aids. If you then wish to take aids into account you will have to reassess with them being used. If you want to do this you must take on the responsibility of ensuring that all aids are government funded whether for mobility or care needs. It would be unfair to reduce someone's entitlement where they have obtained an aid when another person has not been offered the same aid if they have similar requirements. Delivery of aids is piecemeal and inconsistent across the country from anecdotal evidence we have heard. Until you have resolved this it will be difficult to include aids in an equitable fashion.</p> <p>9) The form we had to fill in was large, complex and unclear in some areas as to what was required. I have a Masters degree and still found it difficult and time consuming (over 4 hours) to fill in. We went to a CAB to get it checked and discovered that we had missed the point in 2 or 3 places. It was very much about what could be done not what the claimant was able to do. That aspect could easily be changed. Better use of examples or even a case study in the supporting notes would be a help. I suspect that extensive testing of the form by some current claimants is a key requirement. What about local DWP offices providing a completion and checking service before claims are submitted? Information about the new benefit has to be made more widely available in all types of media. Do not fall into the trap of assuming that everyone has access to the internet or is going to be capable of using it.</p> <p>10) It is unclear as to when you are seeking this supporting evidence. Initially you will have to rely on information provided by doctors, and this should include consultants as well as GPs, and social workers. Subsequently this should be reinforced by the claimant and ought to be checked as part of the assessment process. This whole sequence will have to be covered again during any any periodic reviews. This strikes me as a whole new raft of activities that neither the NHS or the DWP is currently staffed for. Has anyone worked out the additional costs of these activities against projected savings?</p> <p>11) The major benefit will be the opportunity to establish clearly and unambiguously the level of disability and the problems this presents for the claimant. I believe that initial assessments must be carried out by doctors as should reviews to the point where no changes to the level of disability are taking place. After that it may be more useful for reviews to be undertaken by other professionals, such as occupational therapists, appropriate to the claimants disability. I can foresee no great difficulties arising from this</p>

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	<p>other than the need for DWP to employ a much greater number of staff to carry out the assessments and the time it is going to take to play catch up with all existing claimants. It may be inappropriate to carry out assessments in some cases, those suffering from terminal illnesses, for example. I would expect that the majority of meetings would need to be held in the claimant's own home if you are intending to include the use of aids in the assessment test. This is likely to add to the time and effort involved in reviewing existing claimants. Carrying out meetings in other locations would seem to me to be placing an unfair burden on many claimants with mobility problems let alone those with a high level of care requirements.</p> <p>12) The frequency of reviews has to be relevant to the type of disability. It should thus be driven primarily by medical evidence and where this suggests that there are unlikely to be significant changes to the condition then the reviews could be several years apart, possibly as many as 5. With initial claims once an assessment has taken place it would be excessive to carry out reviews more than annually. Reviews must consider evidence from GPs and Consultants other healthcare professionals involved and social workers if appropriate. The claimants themselves are a vital source of information as are their carers. Without understanding what is to be in the new assessments and reviews in detail it is difficult to comment. In principle it is agreed that where someone has a long term condition which is not going to change a few quick telephone calls may be sufficient. Where someone has only recently suffered a problem and changes may still take place then it would be logical to undertake a more detailed review of their position and to do this more frequently, perhaps annually.</p> <p>13) There is no incentive for people to report changes in the current system. They know that there is limited checking of initial claims and that there are few periodic reviews of the type being proposed. It would appear that most of the investigations you carry out are as a result of either tip-offs or because claimants are being investigated by other agencies, such as councils, for other types of benefit fraud. Even if convicted very few fraudsters appear to be jailed and seem to be given long periods to pay back the proceeds of their crime. The fact that you are now proposing reviews and seeking to increase the penalties for fraudulent claims should be enough of an incentive in itself. I understand that the recent trials of future systems have had a good rate of success in deterring dubious claims and would expect this to continue when the system is rolled out across the country. No more incentive needed!</p> <p>?) Assessments for care, getting about and suitability for work would appear to eminently suitable for combining. It may well be that you have to arrange for DWP and council staff to be present at the same time but this should be to the benefit of all especially the claimant. I would expect that all the necessary information could be shared although some elements may not be applicable to all of the benefits</p> <p>?) DLA was fundamental for us in getting rapid access to the Blue Badge scheme, the Warm Front scheme and Carers Allowance. We know of others where it eased access to domestic support and other council controlled benefits. These links appear to work well at the moment but if you were to introduce a qualifying period for PIP these would be broken and add considerably to the burden placed on newly disabled people. It would help if all DWP controlled benefits became accessible through one contact with the department.</p> <p>?) It is of the greatest importance that claimants are given advice and information as soon as they have suffered a disability inducing event. The provision of a "one stop shop" process providing advice and links to the whole range of agencies would be the most useful thing that could be delivered through this reform. However, this is only of use if it is done at the start of a disability. It is of no benefit if there is a delay to meet the requirements of a qualifying period as currently proposed. You would be depriving people of the crucial support they need from the onset of disability. Support delivered a year late is no support at all.</p> <p>We needed advice on:</p> <ol style="list-style-type: none"> <li>a. Claiming DLA, Incapacity Benefit and Carer's/attendance allowance.</li> <li>b. Pre-payment prescription arrangements to reduce the massive increase in costs.</li> <li>c. The Blue Badge scheme to help us getting about.</li> <li>d. Dealing with DVLA about driving.</li> <li>e. Support groups in the area relevant to my wife's condition.</li> </ol> <p>I had to find out about these by myself and contact organisations individually. Others are likely to need advice from their local council about matters it controls such as benefits and domestic support.</p>

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	<p>?) Many of your minority of claimants do not take action simply because they are unaware of what they may be entitled to. A member of my wife's stroke club was unaware of the Motability scheme 4 years after her stroke. She has now improved her quality of life enormously by joining it. There may also still be a number of people, possibly more elderly, who are "too proud" to ask for help they may be entitled to. I suspect that once people are made aware of the support they could get most would ask for it. It is difficult to envisage how you could force someone to take action. You may need to offer to help them to apply to get things rolling once they have been given the information.</p> <p>?) My wife uses a variety of aids from a number of sources. The NHS provides a wheelchair, a stick, braces for her lower leg and a dropped foot stimulator. All of these are at no direct cost. She uses a Motability scheme car funded from her DLA. Everything else has been bought by us. This includes grab rails, a bath seat and a range of devices to assist in the preparation of food. If other items were needed in future such as a stair lift or electrically assisted furniture we would buy these ourselves using PIP. As councils have been hit hard by spending cuts support for the disabled is an aspect that has got worse so people will spend PIP on one-off costs. This will happen regardless of whether pip is intended for these purposes or not.</p> <p>?) Removing the passporting link to other benefits and services would greatly increase the burden on claimants, often at a time when they may be ill-prepared or incapable of pursuing access to them, and when they may most need the additional support. It would also increase the administrative burden on the agencies providing the services or benefits when they have to ask for the same information repeatedly when it could have been gathered once and used many times particularly when different parts of the same department control different benefits.</p> <p>?) The only aspect that I would consider to be unfair is that DLA has been upper age limited in the past. If you are disabled you may need additional support regardless of age. Why should someone over pensionable age not be entitled to this support? In financial terms you may wish to take pension income into account but this benefit is supposed not to be means tested.</p> <p>?) The proposals could offer a major improvement in the way that people with disabilities receive access to and information about the full range of benefits they are entitled to. This could be done in a way which improves and reduces the administrative effort required at both national and local government levels and between the other agencies involved. The major flaw in the proposals is the introduction of a qualifying period. Disabled people need the additional support from the moment the disability inducing event occurs. Six months or a year later is too late. Such a delay may be in breach of your own disability discrimination legislation.</p> <p>I also believe that it is disingenuous of you to use stroke as the exemplar in paragraph 17. Stroke is the single biggest cause of disability in UK and your inference that a large proportion of victims recover to almost normal life is unfair and unbalanced. As the husband of a stroke victim who has met many other victims I believe your paper is presenting an untrue picture which ought to be corrected in your next round of paperwork</p>
ONLINE49	<p>1) The problems and barriers, already in existence for obvious reasons, that prevent disabled people participating in society and leading independent, full and active lives will be exacerbated thousandfold by the proposed scrapping of the mobility component of the benefits for people in care homes.</p> <p>Twice at PM's Questions in the House of Commons the Prime Minister has replied that his government are trying to bring disabled people in care homes in line with people in hospitals. It is clear that in many cases disabled people are in no way the same as hospitalised people. My daughter, aged 23, has Down's Syndrome and heart and lung problems but is very sociable and active and enjoys her college courses, swimming and generally being taken out, as well as coming home to visit her parents, sisters, grandfather and other family members. If she loses this mobility benefit she will in effect be incarcerated in her care home for the majority of the time.</p> <p>2) Yes, the mobility component of DLA should remain for people in care homes.</p>
ONLINE50	<p>1) Discrimination, poor transport, lack of well trained, well paid carers. Poor understanding of some disabilities, eg autism. Disabled people are some of the poorest in the country, day to day living can be a struggle at the most basic level - targetting the most needy is more desirable than the current system, but a decent standard of living should be possible. The current arrangements for the level of mobility allowance does not take into account</p>

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	<p>those with mental health issues (high levels of anxiety, depression, psychosis etc) Police force need more understanding of disability.</p> <p>2) As long as the criteria is needs lead, rather than resource led and each individual's case is looked at when assessments are made.</p> <p>3) Heating, cleaning/shopping - some disabled people are in supported living but do not have the capacity to make decision about routine tasks such as cleaning and shopping. As they spend more time at home, there are extra wear and tear costs on appliances, if the person is incontinent the laundry costs are greater. People with autism may have specific likes and dislikes about food and sensory issues. Particular makes of clothing or type of fabric can have an impact on their budget. Security of the home is vital, so additional arrangements need to be taken into account when assessing need.</p> <p>4) As long as the assessment process is clear and transparent, any documentation written in plain English, there shouldn't be a problem (and provided in a range of formats, of course)</p> <p>5) All claims should be based on the needs and circumstances of the individual applying - therefore assessment process must be undertaken by someone who has an understanding of the disability.</p> <p>6) Health and safety issues, particularly home security is living alone. Personal hygiene, good healthy eating and opportunity for exercise. Motivational activities outside the home. Company - supported living can be very isolating. Access to mainstream activities as well as specialised.</p> <p>7) Review through key worker, or main carer in conjunction with the GP or health visitor.</p> <p>8) Security arrangements eg emergency call out; accessible communication eg phones which are easy to use and understandable (can be v. costly); bathroom adaptations; kitchen equipment; visual timetables/reminders for those with literacy difficulties; more use of adapted technology</p> <p>9) Make the form more user friendly, much shorter, written in plain English. Ensure response is speedy! Adverts on TV, posters in GP surgeries, Childrens' Centres; Schools - all public buildings, eg hospitals, libraries etc</p> <p>10) Key workers, care providers, GPs, carers, voluntary agencies Anyone who has understanding of the individual's needs, disability and ability.</p> <p>11) 1) They need to know the individual being assessed 2) Yes</p> <p>12) 1) Needs-lead, when someone has a disability that is not going to change, eg autism then there shouldn't be a need for change. 2) Possibly</p> <p>13) Send out reminders requiring a response and signature.</p> <p>? ) Cultural differences/needs should be taken into account. Reasonable adjustment must be made to ensure that individuals are not discriminated against. It is also important to respect that some disabled people have set views (ASD) and this needs to be taken into account.</p> <p>? ) Don't really understand this question - why wouldn't they take action, that may suggest they don't have information, or they are OK</p> <p>? ) I have a disabled son with autism. Since becoming an adult, service providers have been unable to meet his needs. This is mainly about lack of training, untargetted support service-led decisions which are all about resources, not about his needs. The poor provision has resulted him in having mental health issues, at times challenging behaviour and confidence is such that he has little motivation to engage with services that are on offer. If he were given appropriate, well timed support - for example when he had a breakdown, an urgent referral to the mental health service, would have prevented the deterioration of his mental well being. He now costs the LA far more because action was not taken when it was needed</p> <p>? ) Isolation, poverty, increased mental health issues, ? ) It is essential that the disabled person has a say in this and most, I would suggest, would be happy for professionals to share information if it speeded up the bureaucracy. OT assessments, podiatry, speech and language services, specialists in the disability.</p> <p>? ) The cost of living is higher for a disabled person than someone without disability, so it makes sense to recognise this. Make the whole system more transparent and equitable.</p> <p>? ) The impact of the child's disability on the family/main carer</p>

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	<p>?) They would need to know about it before putting in a claim, so high profile adverts, information leaflets in targetted places, as above (hospitals, GP surgeries, libraries, buses etc</p> <p>?) Yes, definitely. Family and friends often end up paying for additional costs.</p>
ONLINE51	<p>1) Transport costs - many disabled people cannot afford a car and public transport costs are prohibitive especially if paying for a companion as well, taxi fares are out of the question where public transport is inaccessible. It is also ridiculous to think that legislation outlawing discrimination on grounds of disability will stop disabled people being at a disadvantage especially in the job market.</p> <p>2) passporing to other benefits, especially things like rail cards</p> <p>3) aids, adaptions, assistance delivery charges e.g. for heavy items or even just groceries where the disabled person can't do it themselves having no choice but to pay someone to redecorate for example heating - disabled people are more likely to be at home all day and need the heating set higher to compensate for lack of movement</p> <p>4) I don't see how this will be any easier to understand than having 2 and 3 rates (which I have absolutely no difficulty with anyway) nor easier to administer but it will make it harder to reflect actual needs.</p> <p>5) Some conditions have obvious extra costs which are not dependant on circumstances, e.g. lots of extra washing.</p> <p>6) 1. Obtaining food, shelter, warmth, companionship are most essential. From these remove things other departments are OBLIGED to pay for, the rest have to be assessed. It's no use saying Social Care will pay for someone to do your shopping if they don't for budget reasons. If I can't get food, I can't survive so if social care don't pay for someone to do my shopping, then that's what the DLA will be used for.</p> <p>7) Pay proper attention to what the claimant and/or their direct carer's say about their condition and stop listening to Health Care Professionals who make judgements after 10 minutes of chat.</p> <p>8) Only aids and adaptions already in use should be included. If other appropriate aids etc are available, they should be provided at a cost commensurate with the claimants needs and the claimant reassessed after a period of familiarisation.</p> <p>9) All claimants should automatically have access to independent welfare advisors who can provide targeted advice about gathering information to complete the claim form, and help to complete, e.g. that provided by some CAB advisors.</p> <p>10) The claimant and/or their carers are best placed to describe the daily effects of disabilities and conditions, their evidence should be given priority unless it is not within the 'norms' for someone with that condition. No one who does not know the claimant well is appropriate, and to obtain the sort of detailed information necessary to make a proper assessment would take hours, not the usual 20 minute 'assessment' undertaken at present.</p> <p>11) Absolutely no benefits unless they are vastly different HCPs to those employed at present in the ESA system and vastly different assessments. If face to face meetings are required they should by default be in the claimant's home rather than the false situation of an office. No one should be forced to attend a meeting unless there is a suggestion of fraud, and most especially not anyone with known severe mental health problems.</p> <p>12) The likelihood of conditions changing, adaptation to a condition and/or change in use of aids should be used for frequency. If there is little likelihood of change, a simple form asking if a number of items have changed, e.g. aids used, should be sufficient evidence.</p> <p>13) Don't treat people as guilty until proven innocent and automatically stop payment of all benefits every time someone reports a change of circumstances. If DWP is efficient, overpayments will be minimal or non-existent if changes are reported promptly and dealt with immediately, so make it easy for people. If I have to try 30 times to get through on the phone, I will give up and write instead.</p> <p>?) Almost inevitably from their own funds. For example, many people who would otherwise qualify for motability choose to continue with an old car so that the mobility element covers fuel costs instead, else they would have a car but no means to run it. My dad paid for his own mobility scooter from savings. If assessment is going to be based on use of all possible aids, then there has to be some means of making sure they are actually available.</p> <p>?) An independent 'joined up' disability service should be automatically involved with</p>

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	<p>anyone claiming any benefit as a result of disability, or even who believes themselves to be disabled, with referrals by any and all professionals as well as self-referrals. It can sometimes be frustratingly difficult to get information or advice.</p> <p>?) I have no experience of disabled children</p> <p>?) I would be offended if I was required to access advice or support. I may not appear to do so, but I am perfectly capable of obtaining whatever advice or support I need by myself and would resent busy bodies interfering unnecessarily. The implication would be that I am incapable of taking action myself, which is demeaning.</p> <p>?) It is difficult to combine assessments for different purposes, e.g. ESA and DLA, since the criteria are so different. E.g. social care is subject to budget restrictions as well as need. Assessments are already unreliable, making them more complicated will make them even less fit for purpose.</p> <p>?) Multiple assessments basically for the same thing, what a waste of money! For less often used things, e.g. the railcard, I probably wouldn't have bothered.</p> <p>?) Passporting is sometimes inconsistent, e.g. I qualify for a railcard which gives a discount for myself and a companion, but I cannot get any discount on local or national bus services which I would find much easier to use.</p> <p>?) Quite clearly in the current conditions, savings need to be made, but as a disabled person with a 'lifetime' award of DLA at the highest rate I am beginning to feel that these savings are all going to be made by taking benefits off me. No allowance seems to have been made for the fact that prior to October I had no reason to suspect my income would ever suffer a drastic drop as I drift ever nearer to retirement age, however I now know that within a year or two I will lose my entitlement to contributory incapacity benefit despite paying National Insurance for over 30 years, after which I will not qualify for means-tested benefit due to my husband's pension income, and it now appears that shortly after that I could also lose my 'lifetime' DLA award.</p> <p>I and my family have made major financial decisions, for example my husband retiring early to take care of me, based upon the benefit system then in force. We will now be losing at least £400 per month, and it could be approaching £1000. Had our pension providers done this, would the government be investigating what had gone wrong?</p> <p>?) The only comment I would make is that it is essential to specifically consider the needs of those with mental health problems as well as physical, and particularly how they might interact with physical problems.</p>
ONLINE52	<p>1) I have been disabled for more than 20 years and today still experience more or less the same barriers and attitudes that prevent disabled people from leading independent lives and participate in society on a daily basis. From shops that are either inaccessible or too difficult to use for wheelchair users to offensive remarks such as 'you shouldn't be allowed out', these barriers and attitudes turn daily activities that 'normal' people take for granted into frustrating and often very painful and upsetting ordeals. In theory legislation should have removed or eased these barriers, but in practice the legislation is ineffective both because it is too difficult and time consuming to have any complaint heard and action taken and because breaches are too frequent to report. Therefore the multiple obstacles most disabled people face in all aspects of their lives remain the exactly same as they were when DLA first started and I can't believe the government is naive enough not to know this as well as I do.</p> <p>4) Given that additional costs are very closely linked to the type and severity of disability two levels for each component are not sufficient to account for the large variety of needs involving additional costs. Even the most minor of disabilities will inevitably involve additional costs and should not be ignored.</p>
ONLINE53	<p>1) can't get physically to the place they want to go eg cannot drive, no other means of transport</p> <p>non-disabled people are not accepting of the disabled so the disabled need their own facilities and social opportunities</p> <p>actually being physically unable to interact with non-disabled people</p> <p>difficulty actually getting out of the house eg washing and dressing without support</p> <p>lack of disabled facilities in the outside world eg ramps, toilets, lifts, railings</p> <p>lack of confidence</p> <p>prejudice and stigma</p> <p>bullying</p> <p>lack of money - disability can be a barrier to work therefore many disabled people are on</p>

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	<p>benefits and short of money  exhaustion - physical disabilities especially can leave people easily tired and with less stamina than others</p> <p>2) total freedom to spend the benefit as you see fit, without having to explain or account for your spending</p> <p>3) clothing, transport, personal carers, support groups, extra heating, home adaptations, specialist equipment, specialist clothing, specially adapted vehicles, mobility aids, bath chairs, home-lifts, ramps and railings, specialist therapies not available on the NHS, social opportunities.</p> <p>5) Certain conditions should automatically entitle the person to a minimum level, with an individual assessment giving them the opportunity to increase this to the higher level. For example, a person who is paralysed or has lost a limb or with cerebral palsy who can only get around with a wheelchair should automatically get the mobility part - for obvious reasons. If someone is unable to get dresses, go to the toilet and feed themselves then they should automatically be entitled to get the care element.  If you really want to make this process easier you could have a form which starts by asking a series of simple questions, with yes no answers, the result of which may mean automatic entitlement without the need to fill in a huge form.</p> <p>6) Feeding yourself, going to the toilet, getting dressed, talking to other people in person and on the telephone, writing, communicating effectively, actually getting out of the house and to a given destination, having a bath, getting in and out of bed, managing social interaction with strangers and friends, climbing stairs, understanding danger, understanding of risk and hazards, undertaking physical activity and following health plans and exercise regimes, organising and making plans, going shopping, cooking, cleaning up after oneself, basic housework.</p> <p>8) Only consider what the person actually has and is actually using - you can't take something into account if the person isn't using it, that is ridiculous. If they later get hold of a different aid then they can be reassessed at that time.  Any aids and adaptations in use should be included.</p> <p>9) Tick boxes - can you get dressed by yourself, can you cook your own meal, can you walk for 200 yards, do you need a carer for more than one hour each day etc etc - so much can be covered with a yes or a no which would indicate a very clear level of need without a daunting 40 page booklet of lengthy questions.  Ask lots of smaller simple questions rather than complex long ones.  Send out an example completed form to people illustrating the amount of detail and info required.  Ensure that those who may be entitled have access to independent advice who can help them fill in the forms if required.</p> <p>10) The individual should be asked to provide a list of all the professionals with whom they are in contact and who support them, and then invited to get evidence from them.  Professionals known to and nominated by the individual should be called on, not strangers appointed by the DWP.  Evidence should be anything that these professionals feel is appropriate, but could be a DWP form with tick boxes asking them what the needs and abilities of the person are eg can they walk unaided, can they dress themselves etc.</p> <p>11) This professional will get just a small snapshot of that person - if they are having a "good day" or a "bad day" it will totally distort the impression they give.  Presumably this meeting will occur at an office or surgery - this does not reflect real life and what the individual actually goes through each day.  If it takes place at home it could be extremely intimidating for the individual, like being snooped on.  Individuals should be allowed to have a known supporter or known professional with them for this meeting to make it less threatening.  Individuals should be forewarned what this person is likely to ask them so that they can be prepared.</p> <p>12) Clearly if someone has a permanent disability eg blindness / deafness / paralysis it is obvious that this is not going to improve so they should be exempted from regular review, unless they choose it because they believe they are entitled to more.  At the initial assessment stage it should be obvious that many people fall into this category and should not be reviewed just for the sake of it.  Professionals submitting medical evidence should be asked for their own indication of a</p>

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	<p>prognosis and if it is clear that little change is anticipated then the DWP should bear this in mind when deciding when to review.</p> <p>16) People should be able to use their PIP for anything they see fit. It should not be used for basic equipment which should be provided from separate funding. Such equipment is generally very expensive and should be provided free, if it is agreed that the person is in need of it.</p> <p>17) You MUST take into account the impact of a disabled child on the family as a whole and look into the wider picture, together with Carers Allowance. Many parents give up work to become carers and the financial implications of this need to be considered. The way in which an entire family has to adapt to allow for a disabled child is very hard to quantify specifically but it must be done eg childcare for a sibling because parents are taking disabled child to a hospital appointment etc - they are many many indirect costs associated with disabled children.</p> <p>School and education needs to be kept totally separate from care and mobility. Parents can't be expected to get involved in the funding of school and education, which is already covered by Statements of Special Educational needs - care and mobility requirements are totally separate to this.</p> <p>?) The same evidence should be made available to everyone to reduce the time and effort in getting the same info several times over. In particular this could lead into the Blue Badge scheme which obviously could be linked into this DLA process.</p> <p>?) Clearly it would make it harder and more complex for disabled people to claim other benefits so they would potentially lose out.</p> <p>Mobility is crucial for many disabled people giving them a vital lifeline. This works easily and well and must not be jeopardised.</p>
ONLINE54	<p>1) I can only talk about my son. He is marginalised by society by his lack of speech, his lack of mobility and his lack of intellectual ability. Someone who will never have a mental age of above seven or eight years old, who has little speech and is 'wobbly' when he walks, will always find it hard to participate fully in society and will never be independent.</p> <p>2) I think DLA works well as it is. I see no reason for changing it at all. The right people are entitled to it and, whilst it doesn't cover all additional expenses, the current level of benefit helps.</p> <p>3) Again, I can only talk about my son and the costs we face for him. He cannot walk far so a lot of extra transport expenses are needed. He has epilepsy as well as SLD and autism. I cannot leave him with a 'normal' babysitter but have to pay £15 - £30 per hour to someone who can cope with him and who can use Makaton on the few occasions I leave him. He goes to a Special School where there is After School Cover only twice a week - at a cost of £10 per hour as all the children need 1:1 care. This is far more expensive than normal after school care would be - plus limits my ability to work in paid employment as three days a week I need to be at home with him. He eats/chews/destroys everything - his clothes/the car/sofas/toys which all need constant replacing. He needs a wide range of Multi Sensory Toys and Equipment to relax him - these are expensive and, of course, also get chewed/destroyed meaning they need frequent replacing.</p> <p>4) I think the current system works well. We all know it and understand it.</p> <p>6) I truly believe that children who attend Special Schools should have a priority. The fact that they are disabled enough to be at those schools means that they need extra help. In terms of adults, I think the ability to drive a car (unless living in a city with excellent public transport links) is important. And intellectual abilities. It is very hard to compare someone who cannot walk but who has unimpaired intellectual abilities with someone like my son who is severely impaired intellectually but who can, basically, walk. I feel that my son is less able to cope with everyday activities - he cannot leave the house alone, he cannot dress himself, he cannot go shopping alone, he cannot use any sort of transport alone. Someone in a wheelchair may not be able to walk, but they can do all those things.</p> <p>9) The current form is horrible. I take a fortnight or so to complete it, and I am articulate and able to 'do' forms. It is soul destroying to fill in the form to get my son's benefit - most of the time, I concentrate on the positive things, but the form makes you concentrate on 'what he can't do'. I do one question per day - knowing that most questions will leave me crying. I don't know a way around this - except to say that your staff who assess the forms should be aware of the emotional intensity the forms result in.</p> <p>10) NOT a GP. A lot of disabled children rarely see a GP; they are disabled, not ill. SLTs, Physios, autism experts are all people we have used to provide supporting evidence and it seems to work. I would suggest also not class teachers who only see one side of the child.</p>

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	<p>12) For children and long term disabled adults, I suggest that reviews should be every three to five years. For shorter term things - work related injuries etc - I suggest annually.</p> <p>?) Children tend to have longer term disabilities. They are not going to have work related injuries. Plus, with children, you get the effect of the disability on the whole family and on the parents ability to work. It is not as simple.</p> <p>?) I would suggest that, for a child, you take what is most children's 'average' level of independence at each age group and let the applicant compare their child to that average. For adults, you lay out a list of what is 'normal independence' and compare their abilities to that.</p> <p>?) It is useful in entitling blue badges.</p> <p>?) Please leave DLA alone. parents of disabled children are so stressed and sad already and now it feels as if you are saying that we are making up our child's disability and are threatening to remove our DLA. DLA is my only income. It already doesn't cover the additional expenses incurred by my son and, if you stop children getting DLA - as I have heard you are planning to - then my child and so many others, will end up in Care because we won't be able to afford to keep them at home. This will cost you so much more.</p> <p>?) yes - for a one off cost. DLA does, of course, fund the motability scheme and this should continue.</p>
ONLINE55	<p>1) Guaranteed, stable income in line with what is considered necessary for the rest of the population.</p> <p>Acknowledging in reality - not just playing lip-service to - the fact that a person with a long term/ congenital / non-improving disability is the expert on their own needs and ways of approaching these.</p> <p>Good quality, accessible and adaptable housing - and choice of where to live.</p> <p>Continuing educational / training opportunities to develop or enhance skills and build on levels already held.</p> <p>A ban on the media scapegoating people with disabilities as a group mainly of fraudsters - all because of a tiny minority who do defraud the system.</p> <p>2) DLA was an enlightened recognition that people with disabilities need more of a level playing field if we are to live out the potential we have to make a difference to our own and others' lives.</p> <p>If something is not broken - DLA isn't, in my opinion - don't fix it but fine tune it if required - eg, it seems that many incapacity benefit recipients have been added over the last two years. Perhaps the re-assessments should be limited to these more recent recipients - who do not have a recognised congenital or long-term condition?</p> <p>4) I believe you should have / keep the two rates for each component. it reflects the realities of life!</p> <p>5) Yes, i believe some permanent conditions and impairments should mean an automatic entitlement to benefit where the person requires wheelchair/aids to get around, without which they would be stranded and immobile - eg, Spina Bifida, Cerebral Palsy, Muscular Dystrophy...</p> <p>I have had 56 years of examinations - i don't need anymore! I was recently in hospital for another piece of reconstructive surgery - recurring and deep pressure sores being one side effect of my disability, along with unpredictable digestive problems, poor circulation, sciatic nerve pain, and the aches and pains associated with having severe scoliosis, a rod in my spine and a pin in my hip... What I do need is the stability and peace of mind that comes with knowing that i can pay for the housing and help I need.</p> <p>Having been medically retired from social work - and assessed in 2002 for DLA care component, which i hadn't known i was entitled to - I have used my skills in a voluntary capacity since, supporting many people in crisis situations who cannot access counselling or other 'talking therapies' - i have therefore saved the govt much more than i have received through DLA!</p> <p>(PS - I was encouraged to apply recently for ESA- by an OT, who was shocked i received so little by way of benefits. I applied, was granted a tiny allowance and then decided to go no further with my claim. Why? Because i would have to go through another assessment, fill in a form so intrusive of my intimate physical situation and hear myself and others with a disability spoken of as 'frauds' on TV etc... i have never felt so depressed in my life. So, I decided to say 'no thanks - the cost to my sense of self was too high. Perhaps it is necessary to say that those of us with permanent and congenital disabilities are often likely to understate our situations rather than overstate - we have been so used to getting on with things and boldly trying to go where we are not expected to go...</p>

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	<p>6) As a term, 'Full and active lives' is highly subjective and means different things for different people (disabled and able-bodied) at different stages of life.</p> <p>7) Decide which conditions can fluctuate for the better - ie, go into remission and separate those from others which only fluctuate negatively or remain the same.</p> <p>My condition is congenital, severely affects me and won't go away! While it was relatively stable for the first 30 years of my life, these past 25 have seen change and more problems arising. I see it as up to me to tell you / DLA / DWP when this happens.</p> <p>8) Without my wheelchair, car and crutches i would be helpless. Independence - or self-management - as a concept would be meaningless without these. As would life without being able to pay rent / mortgage for a house / living situation suited to my needs. Also, while i cannot cope without my wheelchair, motability car and limited use of elbow crutches, they come with a price - pressure sores (very poor circulation, many sores in the same places further weakening the skin, scar tissue as a result of surgery to reconstruct damaged tissue) sciatic nerve pain as a result of scoliosis and pain and pressure sore risk from standing more than a couple of minutes. Also, I fall easily if on crutches.</p> <p>9) Sometimes, it doesn't matter how easy you try to make a form, some people just don't 'do' forms or get in an anxious state. Perhaps suggesting the applicant contacts a familiar and trained person is the best way round this. if a form is made too simple it can become worthless. But, plain English does help!</p> <p>10) I am the most competent and best placed expert on my life-long disability. As a secondary source of help, my own GP would be suitable.</p> <p>11) Yes - it is a waste of time and money assessing those like myself who have had life-long contact with the medical profession, support services, and an independent assessment already for DLA. Use your money wisely! Assess new applicants and those who otherwise would have applied for Incapacity benefit these lat two years.</p> <p>(I should also say that some of us, children of the 60's, received what can only be described as abusive 'care' in long-stay wards in hospitals. A genuine fear or reluctance of being assessed / examined yet again is understandable and should be taken into account).</p> <p>12) For those who have life-long and severe disabilities, the review should be either optional, and made via own GP, or asked for by the recipient or recipient's family / carer / partner if unable to make the request independently.</p> <p>13) Do not assume that all people who do not keep the Dept informed do so out of any malice. I can personally imagine not reporting a deterioration in my condition because a) i hope, perhaps unrealistically, that it will get better b) can't see it myself or c) am not wanting to face the fact that i am becoming more limited in what i can do for myself...</p> <p>14) Who the payment is not intended for and where these claimants should be directed instead - eg, people with short-term illness or conditions</p> <p>16) Not sure! Mobility component allows rental of car or scooter. Other aids and adaptations not supplied through NHS funding, OTs or local council grants for house adaptations might be ... Can't imagine what these might be - with perhaps exception of a motorised wheelchair. But I can imagine situations - perhaps few, but still possible - where relatives / carers of people unable to communicate themselves could have their allowances misused.</p>
ONLINE56	<p>1) From my experience it is the ignorance of others about the needs and capabilities of physically disabled people that prevent them from participating. Also, access problems, prejudice of others are a problem. Payments of a disability benefit are hardly going to result in improvements in this. For those who are mentally disabled, it would seem to be prejudice and a lack of awareness from the public.</p> <p>Those who need carers to accompany them when on outings should be paid an allowance te enable this.</p> <p>2) I think the current system of DLA is too easy to defraud. I know of a number of people who claim to be disabled by depression and mental illness who lead much fuller lives that myslef, who is neither physically or mentally incapacitated. They claim to be unable to deal with every day life and cannot venture out on their own. However true these difficulties may be, I cannot see how being given extra money each week can make their lives any better. Especially when they save it up and use it to go abroad on holiday, where their disabilities apparently are not a problem.</p> <p>The current system of not having to have a doctor/specialist assessment seems to be ludicrous to me and that should be the major change.</p> <p>3) transport costs for those who do not drive or have difficulty accessing public transport. payments for carers</p>

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	<p>5) i feel that all claims should be based on the needs and circumstances of each individual, as many conditions or illnesses have different impacts or effects on the individual. Conditions or illnesses that are long term, fatal, terminal, or decreasingly debilitating should give an automatic entitlement. The list of those illnesses should be clearly defined and no claimant should be entitled to claim without a referral from a specialist who can confirm the diagnosis and long term prognosis of the patient. This may make it slightly more difficult in the first instance to claim but would make for a fairer system and those who genuinely claim and deserve the support will realise that this is to protect the system from exploitation by those who claim to be sick and disabled and who actually are not.</p> <p>6) the same kind of activities that are essential for able bodied and non disabled people, yet they are often unable to or prevented from taking part in these activities for a variety of reasons, that no body is interested in.</p> <p>9) the claim form should only be available from a GP or specialist whose knowledge of the patient's condition can support their application. The DWP should employ specialist interviewers to see the claimants, perhaps at job centres, or for those who are unable to attend, to see them at home, to ensure that the claim is completed fully, to reassure the claimant of the process etc and to gather any additional evidence that is required. this may be initially a highly costly exercise, but if in the long run it reduces the amount of fraud committed in these claims it will actually be saving the government hundreds of thousands of pounds.</p> <p>17) unless a child is physically disabled to the degree that they cannot attend an ordinary state school, who needs specialist equipment to enable mobility, or so mentally disabled that they need additional constant attention over and above any child without these conditions, i do not feel that payments should be made for children. Children are meant to be cared for by their parents. It is a costly exercise. There are parents that I know that claim their children are sick or disabled, with conditions such as epilepsy, they claim that their child needs constant supervision etc, because they have looked up the symptoms etc on the internet, and their child is perfectly abled bodied, walks to and from school on her own, has a part time job, no additional care at school etc and the money is used to take the family, who live entirely on state benefits, to Florida every summer. I know other families who have children affected by cerebral palsy, who face some difficulties with mobility and personal care, who do not receive a penny from DLA because their needs are not deemed to be high enough. This system is totally unfair, and, if it was managed in the way that I suggested above, would help to eliminate people who are not entitled from benefitting from a system intended to support the most vulnerable.</p>
ONLINE57	<p>2) the system works well as it is why change it, or is this another back door method of taking it away</p> <p>6) my daughter loves attending the day centre, meeting her friends and doing activities which help in everyday life, the support required is mostly from our borough council eg transport but even that is under review to remove or pass on the cost.</p> <p>13) how can mentally disabled people respond.</p> <p>?) this seems as usual another way of reducing costs and absolutely nothing about the needs of the most vulnerable people in our society.</p>
ONLINE58	<p>1) The main problem is the disability and how severe it is, in my wife's case she has severe rheumatoid arthritis with severe deformities so she can never lead a full and active life. She has a life that is helped by myself but she could never do the things a healthy person could do or the things she would wish to do. I am her husband and full time unpaid carer with out this help she would not be able to do the things she can do. the things she used to do but can no longer do Drive a car, Cook a meal, Shop on her own, Travel on her own, Do the housework, Go for walks, Wear ladies fashion shoes (One of her biggest wishes) she wears slippers or trainers, Be able to bathe herself, Tie her laces, Plus numerous other things a healthy person takes for granted.</p> <p>1) The barriers are not always physical but sometimes conditions like autism can sometimes limit where you can go and what you can do due to inability to communicate, inability to control inappropriate or violent behaviour, irrational fears, etc</p> <p>5) I am no expert but I feel there must be some conditions which are always so serious (and medically provable) that they should give automatic right to entitlement.</p> <p>6) I would say eating, sleeping, toileting, communicating and basic care needs at the very minimum.</p> <p>9) The boxes need to be big enough to be able to include enough information (they are not</p>

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	<p>currently)            ?) Mobility is not considered necessary for children under 5 yet it has been our greatest expense. After diagnosis we were offered early intervention measures which have been shown to make a huge difference in his condition (autism). Although we live in a large city, the only centre providing this (2 sessions for him per week + 1 session for us to improve our understanding = 3 days per week travel) is 20 miles away on poor bus routes. We were unable to get to the centre by bus as we would have missed the bulk of the session time due to no early buses. We had tried to take him by taxi before but he was so upset getting into cars of the wrong type or colour that he would become violent and it was impossible. The only solution was for us to buy a car or we would have had to refuse this vital help at a key point in his development. I don't believe he would have made the improvement that he has if we had not managed to do this. I think the current system is too geared to adults and doesn't take children's needs or welfare into account. I also think the mobility element doesn't take conditions such as autism (and many other) into account where, although the person may be able to physically walk, they may not be able to make reasonable, timely and safe progress towards a given destination.</p>
<p>ONLINE59</p>	<p>1) Some disabled with the right equipment &amp; support have the fitness &amp; stamina to play a full role in society but with others whilst these things help they don't have the fitness stamina to maintain that level of activity. The problem is being able to sustain levels of activity. At home they may be pacing themselves so that they act within what they can manage. The work place or the public place does not have the facilities or flexibility to allow it. eg away from home a warm place to lie down for half an hour whether it be when travelling or shopping or during work</p> <p>2) Support for mobility as transport often needs to be tailored to user and for levels of care</p> <p>3) costs of travel -less tolerance to long journeys means more use of taxis or cars for door to door service. cost of equipment in home and workplace. public places may not have equipment and portable equipment not always available. Delivery costs because shopping cannot always be carried. costs for more heating - if you pace yourself it involves rest periods. costs of medication. costs for tailored holidays because package ones lack flexibility. cost of computer equip to reduce isolation and obtain shopping</p> <p>4) Mobility is tied to key activities of daily life; shopping, work, social, leisure, educational, travel these activities are interwoven with getting around. So is the distinction necessary? why not have several levels that deal with both. Disability is often a mix of factors that prevent people from playing a full part in daily life to varying degrees. Assessors should look at the whole picture and grade accordingly</p> <p>5) Generally on needs &amp; circumstances. But suggest some conditions be prescribed like Multiple Sclerosis or where a medical panel advises that the general level of need is high in over 75% of those with that condition</p> <p>6) personal care eating sleeping social interaction work exercise leisure travel all important for everyday life. added to this is the very high need to prevent isolation of the disabled.</p> <p>7) The assessment has to be tailored so it's not just ticking boxes because the person can or cannot do a task. What stops some disabled is that they can't sustain activity for periods of time. They need to pace, to take breaks to use different equipment, to change position frequently. If someone can do something for one half day it doesn't mean they can do it all week. People need to be able to describe how they manage over longer periods then looked at overall judgement can be made on the severity of their disadvantage.</p> <p>8) Surely it depends on how available they are -if they are everywhere that a person needs to go to live a normal life then that's at one end of the scale -if only in their home then that's at the other end. if they are provided free then the account taken would differ from if payment required.</p> <p>9) 1. give examples of case studies which show slight, medium, severe disability            2. within assessment process allow for people to demonstrate what other (apart from your questions) reasons they have for believing that they are unable to undertake the full range of daily living activities.            3. allow for pacing, pain management issues            4. allow for trained advisors to help process</p> <p>?) It would be an opportunity missed. It was tricky enough finding how to respond to this consultation            ?) Incapacity benefit assessments &amp; DLA assessment</p>

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	?) Motability is all or nothing .For some who only manage a small mileage to have a brand new car is possibly not the best way to provide them with a vehicle.A small loan arrangement can be more economical.It would help if Disability passport could be used across different agencies
ONLINE60	<p>8) No DLA gives people the means to obtain aids and adaptaions that assist them. If benefit is removed when aids and adaptations work you will remove peoples ability to obtain future aids or to update existing ones as required. This is especially important as access to publically available help is disappearing due to swinging council cuts.</p> <p>12) There should very definately be different types of review. My son has Cerebral Palsy and his condition will not change over time. Any review that is more than the single question "Has your condition changed?" will be a complete waste of time and money.</p>
ONLINE61	<p>2) The current rates are easy to understand and should not be changed simply for changes sake. Disabled persons should continue to have personal freedom to use the money as they see fir to improve their lives - especially when it comes to buying mobility equipment such as scooters or using the Motobility scheme.</p> <p>3) Mobility equipment - which is excessively high. Other aids, such as commodes, wheelchairs, walking frames etc. The need to use taxis where public transport is inaccessible.</p> <p>4) The current DLA system has 2/3 components for mobility and care so why should the new benefit be any easier to understand and administer? Indeed it sounds very much more complicated - especially for someone with a permanent and progressive disability. I only had to fill in one form for my current DLA benefit which is for life. Under your proposals I would have to reapply for this benefit at regular periods - even though I have a one-road disability which is only going to get worse. Your consultation also hints that payments for things like new cars under the Motobility scheme might require a special one-off application and decision. So the whole system will be an administrative nightmare involving endless bureaucracy.</p> <p>6) Having as much independence as possible to do the things you want and to play the role you want in society. Good transport and equality of access to shops and other facilities and activities.</p> <p>8) This is a chicken and egg situation. Independence, playing an active role in society and employment is dependent on having the funds to purchase aids - such as mobility scooters and motobility cars - from DLA. No benefit would mean no equipment. Stopping benefit would mean being unable to replace worn out equipment. Equipment like batteries for scooters only have a very brief life.</p> <p>10) Why not - at least - be honest and admit the main purpose of this consultation is to reduce the budget for disabled persons? And I note that you have been very careful not to give any information about how much will be paid with this new PIP benefit. Will the rates be reduced? You claim that this consultation is based on the social model of disability but health professionals will play a key role in determining who should get the new benefit - which takes us straight back to the medical model and disability being seen as a medical problem</p> <p>12) I am disabled and have a progressive condition which will only get worse. Only a miracle cure or new treatment will make any difference and this will not happen in my lifetime. Why do you want to increase bureaucracy - rather than make public sector savings - and make me go through totally needless and expensive reviews?</p> <p>?) I have been in receipt of DLA for over 10 years and much of that time I was in full-time employment. I have since been medically retired. I will be 65 in 2015. Persons over 65 were unable to apply for DLA. Can I be confident that I will switch over to the new benefit and will not be told that I am ineligible for the PIP on age grounds or because I am now retired?</p> <p>?) See my response to question 4</p> <p>?) Yet more bureaucracy!!</p>
ONLINE62	<p>1) Mainly lack of resources/money. DLA payments are not very generous but the lifeline that is Motability does well to keep the disabled people involved in everyday life.</p> <p>2) Any person that has an award for life should not be expected to go through the harrowing new proposed tests. In fact, people recieving for example, mobility component at highest and care component at lowest or middle rate should only be reassessed if they claim for more.</p>

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	<p>3) Having to pay someone to do tasks that able bodied people never think about. Transport and the ever increasing cost of fuel. Heating, as disabled people cannot move about as much to keep warm.</p> <p>4) DLA has two rates as I see it so nothing is changing much. I would suggest that people on lowest rate at present should automatically transfer to the new care rate and only be assessed if the claim for higher. This would save on examination costs.</p> <p>5) Unable to walk without pain and no chance of a cure through joint replacements for example.</p> <p>6) If people can hardly walk due to pain, they need the independence of a car to get from A to B and live some sort of life. Claimants medical records should show genuine disabilities.</p> <p>7) The claimant's medical records at general practitioners along with hospital reports should always be brought together when testing.</p> <p>9) Again. Instead of the claimant being examined by the nominated doctor, their medical records from every source will show if there is a long term disability. Claimants cannot always explain their problems in one assessment session due to fear and intimidation. Most people feel that they are not being believed. The form should be short and to the point and always be looked at in conjunction with the claimants medical records.</p> <p>10) Simple. Bring together all medical records and reports.</p> <p>11) The claimant should be offered the chance to have the discussion recorded on video and always at his/her own home.</p> <p>12) Some conditions will never get better and no review should be required unless the claimant claims for higher care.</p> <p>13) You could, for example, have hospitals inform DWP of joint replacements or aids and then reassess the claimant if they do</p> <p>?) Again, most claimants feel under pressure with explaining disability. Why not allow their GP to be present?</p> <p>?) I can only speak personally about what it has meant to me. Mobility at highest rate allows me to have access to a car that I could not otherwise afford. care component at the lowest rate helps buy medicines as I do not qualify for free prescriptions. Other than that, my total income from a small private pension is £95 a week.</p> <p>?) I don't understand this question and I'm sure the number of likewise people will be high.</p> <p>?) I feel the disabled people in our country are being very badly let down by this proposal. I feel that every case could be looked at without an examination. Ask claimants to allow access to their medical records and if they refuse, this is the people who may have something to hide and should be reassessed. Some claims would be so straightforward that no tests/discussion would be required thus save money.</p> <p>?) I like almost every other person sees this as a government money saving measure. The coalition states that it expects to save money with this thus, they assume that 20/30% of claims are false. Genuine disabled people will suffer because they cannot and have not the ability to put themselves across. they should be represented at tests.</p> <p>?) Most disabled people I know use their DLA mobility component for cars or aids and adaptations. If the government think that supplying all disabled people with say, a small UK produced car we would be going back to the bad old days before the Thatcher government gave disabled people dignity.</p> <p>?) Not sure about this question.</p> <p>?) Once again, claimants full medical records from all sources should be looked at at any claim for benefits.</p> <p>?) Something must change here. The child's GP should represent the child along with parents or any relevant medical person in that child's life.</p>
ONLINE63	<p>1) ill health medication which sometimes numbs the mind and sometimes looking well to others while feeling dreadfully ill</p> <p>2) I personally took a loan to adapt my home because the council would have to take a year or more for funding, I use my allowance to pay that loan so any reduction would be disastrous for many like myself.</p> <p>3) extra heating because we feel cold sometimes on what many would consider a warm day. trips to regular hospital appointments and doctors surgery. and chemist all cost petrol and without a mobility vehicle living as we do in a rural area would be distress as some of my hospital appointments are in the city</p> <p>4) I think some people wrongly could miss out on a two tier system and some are afraid to ask for reassessment.</p> <p>5) yes in circumstances where we have seen all the specialists and been awarded</p>

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	<p>indefinite awards which in my time was lifetime awards we have already been through hoops with specialists who have confirmed we will get no better in many cases we are worse as we get older, my wife for instance is typing this for me as my right arm is frozen and i am now also diabetic as well as my others illnesses</p> <p>6) keeping warm and supporting our carers my wife bless her does a wonderful job of keeping the home spotless as well as changing and washing bedding when i have accidents caring for all my needs being there for my family and grandchildren of which i have 8.</p> <p>7) this is a difficult area. as well as my damaged discs and arm problems and ulcerated colon i also suffer fibromyalgia which can attack any part of the body at any time and sometimes although not often one can feel quite well but it doesn't last and as well as morphine i have to take gabapentin for diabetic nerve pain which can sometimes mask the symptoms but are no long term cure and have their own drawbacks such as making you very sleepy and sometimes stomach problems</p> <p>8) i have great difficulty with my one leg and hip and should use a cane but because of my right arm problems i tend to lean on my wife and only use the cane when my arm is okay which is usually after it is injected but that is only short term fix and can only be injected twice a year but overall i think you should help better with aids but it all comes down to cost</p> <p>9) i personally found the forms okay as i used a welfare worker from our local council and i just answered the questions and my doctor at that time 1993 checked them for accuracy before we sent them to disability.</p> <p>10) i think overall your doctor knows all about your history as they send you to see specialists etc and know your case.</p> <p>11) in keeping with the afore mentioned question if the health care official is provided with an assessment from your gp then they would appreciate any problems that are likely to arise.</p> <p>12) that would be at the departments discretion but as now i think if a person has illnesses that are impossible to cure and prevents them from working then it would be a waste of tax payers money to keep relieving what can not be cured and in some cases i think as of now indefinite should apply in these cases.</p> <p>13) i understand my obligations well i have an indefinite award at present which was awarded 1993. since then i have several other problems such as severe attacks of vertigo which causes sea sickness type symptoms i have also developed diabetes and mri scans have confirmed prolapsed spinal and shoulder discs. had my condition improved i would have informed the dwp but as it has become worse i can't see what difference it could make to my award</p> <p>?) above all people need to feel treated fairly and not as a cost cutting exercise</p> <p>?) i personally purchased my own form the hospital at reduced rate but im sure people who need wheel chairs should have help</p> <p>?) i personally was explained all my benefits by the welfare officer who helped with my claim</p> <p>?) i personally would have no problem with all my benefits lumped together in one place.</p> <p>?) i think adverts and leaflets are a good idea.</p> <p>?) i think it would cause major headaches for claimants and dwp alike</p> <p>?) i think people are concerned that pip is a cost cutting exercise and disabled people need assurance that they will be treated fairly</p>
ONLINE64	<p>1) I have rheumatoid arthritis with heart and lung complications.</p> <ol style="list-style-type: none"> <li>1. Physical barrier - weakness and loss of function of parts of the body</li> <li>2. Pain</li> <li>3. Cost - all my money goes on help - personal help subsidiary help ie keeping my environment clean and safe buying and maintaining aids eg car, wheelchair, scooter, bath and mobility aids, other household aids and adaptations. There is no money for holidays, outings, etc and little for clothing. Also for treatments such as acupuncture, massage. Everything costs more if you are disabled and cannot use public transport - even hospital parking, someone to drive and assist me.</li> <li>4. We have to pay for care which we used to obtain free in hospital, despite actually being ill eg from flare ups, or operation - when one is discharged and expected to manage at home on one's own, especially at night.</li> <li>5. Attitudes and lack of understanding including from professional staff like doctors, nurses, etc</li> <li>6. Anti discrimination legislation does not solve problems we face.</li> </ol>

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	<p>2) 1. ITS NAME!! WHY ON EARTH CHANGE THE NAME? EVERYBODY RECOGNISES DLA. NOW WE ARE GOING TO BE IN RECEIPT OF PIP!!!  THE COST OF A CHANGE EVEN IF ONLY THE NAME IS ASTRONONOMICAL. STATIONERY, PERSONNEL, EXTRA TRAINING ETC. THIS MONEY IS WASTED AND WILL NOT BE RECOVERED THROUGH ANY SAVINGS FROM THE NEW SYSTEM. YOU COULD JUST REVISE THE PARTS OF DLA WHICH NEED REVISION AND IMPROVE IT INSTEAD.  AT THE MOMENT YOU ARE WASTING VAST AMOUNTS OF MONEY BY USING PRIVATE AGENCIES TO DELIVER CARE AND OTHER THINGS. EVERY PENNY OF PROFIT THEY MAKE IS A PENNY TAKEN AWAY FROM THE PEOPLE YOU ARE SUPPOSED TO BE SUPPORTING AND ON TOP OF THAT THE COSTS OF PRIVATE ORGANISATIONS ARE HIGHER THAN DIRECTLY EMPLOYED STAFF.THESE EXTRA COSTS ARE PASSED ON TO RECIPIENTS. THE CARE THEY PROVIDE IS ALSO DISJOINTED INCONSISTENT AND SUBSTANDARD.NOT PROPERLY MANAGED. YOU SHOULD FIND OTHER WAYS OF SAVING MONEY - NOT ATTACK THOSE WHO CANNOT FIGHT BACK.</p> <p>2. DIRECT PAYMENT INTO BANK ACCOUNT SHOULD REMAIN.</p> <p>3, SELF ASSESSMENT IN DETAIL SHOULD REMAIN DESPITE LENGTH OF FORM, BUT THE FORM ITSELF COULD BE REVIEWED AND SUGGESTIONS INVITED FROM DISABLED PEOPLE AS TO HOW IT MIGHT BE IMPROVED.</p> <p>3) IT'S NOT THE 'MAIN' COSTS' THAT ADD UP BUT THE COUNTLESS LITL E EVERYDAY COSTS.  COSTS OF EVERYTHING THEY CANNOT DO FOR THEMSELVES - IN MY CASE, WALK, DRIVE, VARIABLE ABILITY TO WASH, DRESS, KEEP MY HOME CLEAN, LAUNDRY, DO MY OWN PAINTING AND DECORATING, GROW MY OWN VEGETABLES, USE PUBLIC TRANSPORT (YES, REALLY! HAVE TO PAY FOR TAXI OR CAR, PARKING CHARGES, INCLUDING HOSPITAL), GO SHOPPING ( THINGS COST MORE TOO IF YOU CANNOT LOOK FOR BARGAINS), ALL AIDS,EG WHEELCHAIR, SCOOTER, WALKING AIDS, BATH AND KITCHEN AIDS ETC ETC eVERY ASPECT OF LIFE COSTS MORE. ALSO, NOT BEING ABLE TO GO TO HOSPITAL WHEN NEEDED DURING A BAD SPELL, WHEN WE HAVE TO PAY FOR CARE WHICH SHOULD BE FREE BECAUSE IT IS DUE TO A MEDICAL CONDITION.ALSO EARLY DISCHARGE AFTER OPERATIONS - YOU ARE LEFT TO MANAGE ON YOUR OWN.HELP WITH WASHING, IRONING, EVEN MENDING, CLEANING THE CAR, WINDOWS, TIDYING THE GARAGE, CLEANING CUPBOARDS, HAVING TO USE EXPENSIVE READY MEALS INSTEAD OF COOKING. NEVER HAD A HOLIDAY BECAUSE I COULD'NT GO ON MY OWN. I AM SURE THERE ARE MORE THAT I HAVE FORGOTTEN.</p> <p>4) IT WILL PROBABLY BE EASIER TO ADMINISTER BUT NOT AS ACCURATE . HAVING ONLY TWO RATES WITH A WIDE DIFFERENCE BETWEEN THEM CARIES THE DANGER OF AN ENORMOUS EFFECT ON WHAT A PERSON RECEIVES - ALMOST TO THE EXTENT OF 'ALL OR NOTHING'.  IT ALL DEPENDS ON THE JUDGEMENT OF ONE PERSON,AND IT IS IMPOSSIBLE TO HAVE CONSISTENT ASSESSMENTS ACROSS THE BOARD.WE HAVE ALL SUFFERED FROM THE SUBJECTIVE JUDGMENTS OF DIFFERENT ASSESSORS WHO HAVE THE POWER OVER ONE'S ENTIRE LIFE. THE DLA FORM MIGHT BE LONG BUT IT DOES SHOW UP THE DIFFERENCES IN NEED BETWEEN INDIVIDUALS. SOME CONDITIONS ARE VARIABLE FROM HOUR TO HOUR, DAY TO DAY, WEEK TO WEEK.  THERE IS GREAT POTENTIAL FOR MISTAKES.</p> <p>5) A YEAR IS A LONG TIME TO HAVE TO FIND WHAT COULD BE A GREAT DEAL OF MONEY TO COVER THE COST OF MANAGING WITH A DISABILITY. IT WOULD BE DIFFICULT TO ASSESS THE PROSPECTIVE NEEDS OF SOME CONDITIONS. IT SHOULD ALWAYS DEPEND ON INDIVIDUAL NEED AFTER SIX MONTHS AT WHICH POINT IT SHOULD BE PAID IN RETROSPECT IF NECESSARY.  PEOPLE WHO ARE PERMANENTLY BLIND WITHOUT ANY PROSPECT OF IMPROVEMENT. PEOPLE WHO HAVE PERMANENT PHYSICAL OR MENTAL CHANGES EG BRAIN DAMAGE OR PHYSICAL DEFORMITY. THE COST OF HAVING TO DO REPEATED ASSESSMENT OF SOMEONE WHO IS OBVIOUSLY PERMANENTLY AND SERIOUSLY IMPAIRED COULD BE WASTE OF MONEY.</p> <p>6) SEE ALSO MY ANSWER TO QUESTION 3.</p>

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	<p>IF YOU COMMIT TO PROVIDING SUPPORT TO LIVE FULL AND ACTIVE LIVES, YOU MUST ASSESS EACH PERSON INDIVIDUALLY AGAINST THAT CRITERION. YOU CAN'T PRIORITISE. YOU EITHER MEET THAT CRITERION OR NOT. YOU CANNOT ONLY SUPPORT THOSE WITH THE MOST NEEDS. THIS IS WHAT IS HAPPENING TO SOCIAL CARE AT PRESENT - ONLY THOSE WITH THE HIGHEST NEEDS ARE BEING CARED FOR - MAINLY BECAUSE SO MUCH MONEY IS BEING WASTED - GOING INTO THE POCKETS OF PRIVATE COMPANIES CHARGING HIGHER RATES IN ORDER TO MAKE PROFITS.</p> <p>7) THE ONLY WAY YOU CAN DO THIS IS BY SELF ASSESSMENT BACKED UP BY PAST EVIDENCE FROM THE PERSONS MOST ABLE TO PROVIDE IT, EG HELPERS, CONSULTANTS. THIS MUST NOT BE LIMITED BY RIGID RULES EG GPS ARE NOT ALWAYS AWARE OF THESE CHANGES IN ANY DETAIL WHILE CONSULTANTS MIGHT WELL BE. THIS IS ANOTHER EXAMPLE OF NEEDING TO USE THE MEDICAL MODEL OF DISABILITY AS WELL AS THE SOCIAL MODEL.I AM A PRIME EXAMPLE OF HAVING A VARIABLE AND FLUCTUATING CONDITION (RHEUMATOID ARTHRITIS). MY CONDITION CAN CHANGE HOUT TO HOUR, DAY TO DAY, WEEK TO WEEK, MONTH TO MONTH. A NEW DRUG MAY WORK THEN SUDDENLY I HAVE A FLARE-UP. A SUDDEN INFECTION CAN CAUSE A FLARE UP. WHEN THIS HAPPENS I AM SUDDENLY HELPLESS.I AM UNABLE TO ATTEND MEDICAL APPOINTMENTS IN THE MORNINGS BECAUSE I CANNOT DO HALF AS MUCH (EG GETTING IN AND OUT OF CAR) AS I CAN IN THE AFTERNOON. I GO TO BED AT 6 OR 7PM BECAUSE I AM EXHAUSTED.</p> <p>THE ADVANTAGE OF A CONSISTENT PAYMENT OF DLA IS THAT I CAN EMPLOY MY OWN HELPERS. I CHOOSE THOSE WHO ARE ADAPTABLE TO ME CHANGES. I QUITE FREQUENTLY HAVE ATTACKS OF ATRIAL FIBRILLATION WHICH MIGHT REQUIRE BEING TAKEN TO HOSPITAL ALBEIT BRIEFLY. I MIGHT NEED MY HELPER TO STAY OVERNIGHT AT A MINUTE'S NOTICE. I LIKE TO BE AS INDEPENDENT AS POSSIBLE - WASH AND DRESS MYSELF ETC. AT VERY SHORT NOTICE I MIGHT NEED A LITTLE HELP FOR A DAY OR TWO, TO A LOT OF HELP FOR WEEKS.</p> <p>I HAVE A WHEELCHAIR WHICH I AIM TO USE AS LITTLE AS POSSIBLE, IN ORDER TO KEEP ALL MY JOINTS WORKING. AN ASSESSOR MIGHT THEN THINK I DON'T NEED IT.</p> <p>8) ANY PERSON WHO THINKS FOR ONE SECOND THAT AN AID OR ADAPTATION CAN RENDER A DISABLED PERSON NORMAL IN RESPECT OF ANY ACTIVITY WHATSOEVER, CAN HAVE ABSOLUTELY NO UNDERSTANDING OF DISABILITY AND ITS COMPLEXITY. THE SUGGESTION IS OUTRAGEOUS. IT DOES NOT MATTER WHETHER THE AID OR ADAPTATION IS SMALL OR LARGE.</p> <p>EXAMPLES:-</p> <ol style="list-style-type: none"> <li>1.THE ONLY DIFFERENCE A RAMP MAKES TO A BUILDING IS THAT A PERSON CAN GET IN AND OUT OF THE BUILDING. IT DOES NOT MAKE THEM ANY MORE BODILY ABLE IN WHAT THEY HAVE TO DO.</li> <li>2.WHEELCHAIR. A PARALYSED PERSON MIGHT LIVE IN A WHEELCHAIR PERMANENTLY. IT DOES NOT TAKE THE PLACE OF LEGS AND MIGHT NOT RELIEVE PAIN. MUSCLES BECOME WASTED WHICH BRINGS ITS OWN PROBLEMS. PEOPLE GET PRESSURE SORES. HAVING TO DO ANYTHING FROM A WHEELCHAIR IS NOTHING LIKE NORMAL.THEY STILL NEED TO PAY FOR HELP TO COVER ALL ITS LIMITATIONS, MAINTENANCE AND REPAIRS ETC.SOME PEOPLE USE A WHEELCHAIR INTERMITTENTLY. i TRY TO USE MY WHEELCHAIR AS LITTLE AS POSSIBLE SO AS NOT TO LOSE THE USE OF MY LEGS.ITS USE IS ONLY RELATIVE - IT CAN NEVER MAKE ME AS ADEPT AS AN ABLE BODIED PERSON.</li> <li>3. WALKING STICK, FRAME, CRUTCHES.NONE OF THESE MAKE UP FOR LOSS OF MOBILITY. YOU HAVE TO USE YOUR HANDS AND ARMS TO WALK WHICH MEANS YOU CANNOT USE THEM FOR THIER NORMAL PURPOSES.</li> <li>4. EVEN BATHROOM OR KITCHEN AIDS DO NOT MAKE UP FOR NOT BEING ABLE TO USE ONE'S BODY FOR ITS INTENDED PURPOSES. RAISED TOILET SEAT ONLY MEANS THAT IT IS EASIER TO GET UP - YOU STILL HAVE OTHER LIMITATIONS IN USING THE TOILET EG PAIN.</li> </ol> <p>I CANNOT THINK OF A SINGLE AID THAT BRINGS ME ON A LEVEL WITH AN ABLE-BODIED PERSON.I SUGGEST THAT ALL ASSESSORS BE FORCED TO LIVE IN A WHEELCHAIR FOR A WEEK AND SEE IF THAT EQUATES WITH BEING ABLE TO WALK.</p>

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	<p>9) I HAVE ALREADY COVERED THIS IN PREVIOUS QUESTIONS TO SOME EXTENT. THE CLAIM FORM MUST OF NECESSITY BE LONG IF IT IS TO COVER ALL THE CLAIMANT'S NEEDS. I CANNOT SEE WHAT ADVANTAGE THERTE MIGHT BE IN BEING 'POSITIVE'. THIS BENEFIT IS SUPPOSED TO COVERING WHAT A PERSON NEEDS AND OF NECESSITY MUST COVER WHAT THEY CANNOT DO AS OPPOSED TO WHAT THEY CAN DO.</p> <p>THE SECOND PART OF THE QUESTION IS DIFFICULT BECAUSE WE STILL DO NOT KNOW WHAT THE GOVERNMENT IS AIMING TO DO. IT SEEMS TO MOST OF US THAT THE ONLY REASON FOR ALL THIS UPHEAVAL IS TO SAVE MONEY, WHICH CANNOT BE DONE WITHOUT DEPRIVING US OF MORE THAN WITH DLA. YOU CAN INVESTIGATE FALSE CLAIMANTS JUST AS EASILY WITH DLA AS WITH THIS NEW PIP. YOU CAN ENCOURAGE AND HELP PEOPLE TO WORK JUST AS EASILY WITH DLA.</p> <p>WE SUSPECT THAT YOU WILL CHANGE THE CRITERIA ACCORDING TO YOUR OWN INEXPERIENCED IDEAS OF WHAT PEOPLE CAN DO OR NOT DO, AND GIVE US LESS MONEY AND HELP.YOU ARE WASTING AN ENORMOUS AMOUNT OF MONEY JUST DOING THIS. I EXPECT WE WILL SUFFER FOR THAT.</p> <p>IT DOES NOT NEED A ROCKET SCIENTIST TO EXPLAIN TO YOU WHERE YOU ARE GOING WRONG AND NOTHING WE SAY IS GOING TO HELP.</p> <p>10) AN ASSESSMENT SHOULD INCLUDE SUPPORTING EVIDENCE FROM PROFESSIONALS WHO KNOW THE PERSON CONCERNED WELL PLUS A DETAILED MEDICAL ASSESSMENT, INCLUDING ALL x-RAY REPORTS OR OTHER APPROPRIATE INFORMATION.YOU CANNOT IGNORE THE MEDICAL MODEL OF DISABILITY.ALSO THE PERSON'S FAMILY,AND HELPERS.</p> <p>11) EARLY ON IN MY DISABLED LIFE I EXPERIENCED FACE TO FACE DISCUSSIONS WITH HEALTHCARE PROFESSIONALS. ONE APPROVED DOCTOR RECOMMENDED THAT I GO FROM THE MIDDLE TO THE HIGHER RATE AFTER GOING THROUGH EVERY ASPECT OF MY EVERYDAY LIFE - I EVEN HAD TO DEMONSTRATE HOW I WIPED MY BOTTOM! THE POWERS THAT BE WERE NOT HAPPY WITH THIS SO THEY SENT AN OBNOXIOUS LITTLE CHARACTER WHOSE SOLE PURPOSE WAS TO GAIN APPROVAL FOR HIMSELF BY SAVING AS MUCH MONEY AS HE COULD - HE POOH-POOHED AND DELETED EVERYTHING THAT THE PREVIOUS DOCTOR HAD SO PAINSTAKINGLY INVESTIGATED, - AND STOPPED MY DLA. IT TOOK ME TWO YEARS TO GET IT BACK AND CAUSED ME ENORMOUS HARDSHIP. SO I TRUST NO-ONE.</p> <p>I HAVE ALSO ENCOUNTERED GOOD OCCUPATIONAL THERAPISTS AND BAD OCCUPATIONAL THERAPISTS - THERE IS NO CONSISTENCY. EVEN GPS ARE HAZY AS TO EXACTLY HOW WE MANAGE AT HOME.</p> <p>THE AIM OF THE ASSESSMENT SHOULD BE MADE CLEAR - IF IT IS TO BENEFIT THE PERSON CONCERNED THEN THIS SHOULD BE MADE CLEAR.SOME PROFESSIONALS SEE THEMSELVES AS SORT OF POLICEMEN WITH A DUTY TO CUT EXPENDITURE AT ALL COSTS.THERE SHOULD BE A SAFEGUARD AGAINST THIS BUILT IN. PERHAPS AN APPEAL SYSTEM WITH TIME LIMITS, OR ALLOWING THE PERSON TO CHOOSE WHICH PROFESSIONAL SHOULD DO IT.</p> <p>IT SHOULD BE INAPPROPRIATE TO MAKE A PERSON OF SAY OVER 70, GO THROUGH THIS AFTER A CERTAIN TIME ON THE TOP OR MIDDLE CARE AND MOBILITY LEVELS, AND WHERE THE DISABILITY IS SO OBVIOUS THAT THERE IS ABSOLUTELY NO DOUBT. A CERTIFICATE OR LETTER FROM A PATIENT'S CONSULTANT OR PROFESSIONAL WHO IS FAMILIAR WITH THE PERSON SHOULD BE ENOUGH.</p>
ONLINE65	<p>1) the attitude of society in so far as if you challenge people you just get either ignored or patronised This country has a long way to go in terms of improving the rights of disabled people to participate in society But as we have only had legislation in this field for 15 years perhaps its a little early judge Personally you either like me or you dont me but I am a person with a disability not a disabled person</p> <p>2) yes it should be paid to the individual including those in residential care Not means tested The decision about entitlement should be based on the individuals view of their situation</p>

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	<p>much as in the current system</p> <p>3) in my case transport if i want to travel to Shrewsbury a journey of 3 miles using my wheelchair A taxi costs me £7 one way I cant rely on using public transport because the bus company is unable to guarantee wheelchair accessible vehicles and the ones that are supposed to be very often arent working so free public transport bus pass is of little value to a wheelchair user if i use a taxi to take me to work i would spend all my DLA on those journies Extra heating particularly in the winter Higher electricity costs for more washing of clothes particularly for people like me who are incontinent</p> <p>4) it will make it easier to understand but harder to administer at the margins particularly if the difference between the two levels are set too great Do you intend using a points system in the style of the old incapacity benefit system ? may lead to more appeals and therefore more bureaucracy as you are having to fit individuals into 2 boxes</p> <p>5) yes i think that anyone with a condition that is life long congenital or via accident should qualify without an assessment (current claimants should have some protection at current levels of benefit this is a false division since you are not intending to assess all claimants on an individual basis but against some kind of scoring system The booklet refers to medical improvements since 1992 but this is disingenuous to say the least since no amount of stem cell research will in my life time repair my Spina Bifida beyond the surgical repair I had in 1961 A situation that applies to a wide range of disabilities which currently enable people to qualify for DLA</p> <p>6) doing what anyone else would do and having the freedom to do that going to the theatre sports stadiums concerts Limited opportunities due to inadequate public transport and high costs of wheelchair accessible taxis in Shrewsbury The Prime Minister needs to understand the difference between DLA recipients in hospital and those in residential care homes In a recent Commons debate he seemed somewhat confused about this (see Hansard and Lord Rix letter to the Guardian on this point. need to have a system that allows people in residential care to have some input into how the DLA and its successor benefits are used</p> <p>8) Ok so now we are the point where if you have a mobility problem get a wheelchair If you are visually handicapped get a white stick or a Guide Dog My crutches and callipers are essential items which enable me to walk</p> <p>Scenario If the government decides to take into account the aids people might be eligible for who is going to decide how long people have to wait for those adaptations/aids</p> <p>2)I choose to use a wheelchair in my daily life because I am a pragmatist and know it enables to me to take a more active role in society. However I would be strongly against a Benefit system deciding that I should use a wheelchair in order to reduce my Benefit entitlement</p> <p>3) in terms of major adaptations to a household who is going to decide what adaptations should be included and the ease with which they can be obtained</p> <p>10) a doctor however I suspect it will be a health professional who probably wont have a clue about your disability (I have experience of these assessments from a professional viewpoint ie being asked if I was born with Spina Bifida Medical evidence use of video claimants views to provide a total picture</p> <p>11) yes if that person has difficulties explaining their needs the nature of the questions which in my opinion are probably going to be designed to illicit information whilst on the surface appearing to be quite innocent We are talking about an Incapacity Benefit interview arent we conducted by a private sector medical firm with payments by results ie making</p>

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	<p>decisions that reduce benefit entitlement</p> <p>13) prosecute all failures to notify changes of circumstances and publicise the fact more openly As a person with a disability</p> <p>I would back such a move 100%</p> <p>How much more straight forward can the award letter be in terms of change of circumstances</p> <p>?) No there shouldnt</p> <p>?) use receipt of P.I.P. to be a passport to premiums on other DWP benefits as DLA is now</p> <p>Could combine assessments for ESA and P.I.P. now thats a thought to gladden Chris Graylings heart.</p> <p>One process for all benefits</p> <p>Blue Badge Parking scheme</p> <p>?) Yes but again this will be limited</p> <p>Citizens Advice Bureaux facing cuts in funding</p> <p>Jobcentre Plus offices not enough resources to assist customers</p> <p>Need to identify who these customers are but if they dont claim how can they be identified poss via the GP service</p> <p>Other health professionals</p>
ONLINE66	<p>1) My 45 year old daughter has profound learning disability and very limited mobility, walking only a few yards with support. She lives in residential care and uses Mobility Allowance to pay her share of the contract hire and petrol for a wheelchair vehicle. She has no speech, no ability to motivate any activity and little concentration to participate in craft or table activities. Without the Mobility Allowance she would not leave the bungalow where she lives and would be confined to watching TV all day. She currently enjoys attending a Day Centre, a special weekly club, weekly wheelchair dancing, and a monthly disco - all accompanied by a staff member of course. Most of her pleasure is derived from watching other more active members. None of these activities would be possible without transport paid for by Mobility Allowance and if this were removed, her Statutory Allowance would not be sufficient for even one taxi outing.</p> <p>3) Those with profound learning disability always need to be accompanied by a helper and for any meals or snacks out, the expenses of the helper must also be paid by the service user.</p> <p>5) If someone can walk only a matter of yards holding on to a person or appliance, there should be an automatic entitlement to Mobility Allowance. Many who have walking difficulties tend to deteriorate as is the case for my 45 year old daughter, who received a letter of entitlement to Mobility Allowance until she is 65, which now seems in doubt under the reform proposal.</p> <p>6) 1)Those who are too handicapped to use public transport. 2)Getting out of the house occasionally!</p> <p>7) Regular health checks on those with fluctuating conditions. Those who are genuine will not argue with this. Those already assessed as unable to improve, as with profound birth handicaps, would not need further checks as miracles are unlikely!</p> <p>11) Anyone making a genuine claim will be happy to attend a face-to-face meeting. My daughter's original assessment took place at a surgery with no carparking facility. There was considerable anger among the carers of the handicapped people, one man having to carry his adult son from the nearest street parking.</p> <p>?) My daughter's wheelchair and motorised wheel was bought using Mobility Allowance.</p> <p>?) Mobility Allowance enables user to apply for a Blue Badge and ceretain parking permits.</p> <p>?) The Mobility Allowance should not be removed from disabled people living in residential homes. This is discrimination against them only by reason of their handicaps being so great as to not being capable of being managed at home, so they lose out twice. Residential homes are already run on tight budgets, paying only minimum wages to staff and will certainly not be able to afford to run transport for their residents to access leisure opportunities.</p>
ONLINE67	<p>1) Extra costs for care, transport, mobility. Difficult to use public transport.</p> <p>2) Ability to spend the Disability money in the best way, for care , food, transport .</p> <p>3) As above, care, mobility, transport, sometimes special food. Medication. Difficult to use public transport, so sometimes need taxis. Also their carers do need a break.</p> <p>4) It could be easier, but it could also be more difficult, like Attendance Allowance, to prove</p>

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	<p>the 'higher rate'. People are put off applying for the 'higher rate' think they do not meet the criteria.</p> <p>5) Some health conditions should be automatic, for example I have a friend, aged 65, with long term,( since aged 6,) polio, she will never improve. Not sure which conditions could count, for example Parkinsons Disease is one.</p> <p>6) Personal care, food and drink, medical needs. Social activity, interact with others.</p> <p>7) Monitor to see if the person's condition has worsened, most people will not improve. '</p> <p>8) Take into account in a positive way, not to say with aids the person is improved, and does not need benefits. People I know on Disability Living Allowance buy their own aids from the benefit, as not easy to lease them. Consider aids the perosn may need to buy in the future.</p> <p>9) Make the claim form fairly short, and in basic English. Disabled people do not feel like completing complicated forms, I have helped my friends. Consider evedience from GPs ,social workers. Publicise the new benefit in Gps, libraries etc.</p> <p>10) As above, Gps, social workers can give supporting evidence.</p> <p>11) People automatically think the face to face discussion is to stop their benefits. Inappropriate if terminal illness, or severe and complex disabilities</p> <p>12) Once a year, face to face or telephone. In between, self reporting, evidence from GPs, social workers etc. Reviews can work both ways, condition improved or worsened.</p> <p>13) Make it clear there are penalties for not reporting changes, but also that changes may be to the claimant's advantage.</p> <p>? Advice re other benefits, and help with caring. It would be helpful to provide this, as the care system is a minefield, carers and disabled people often do not know who to contact.</p> <p>.</p> <p>? Children 's needs can change as they grow. Need to be more sensitive if interviewing children too.</p> <p>? Disabled people I know save up for aids from the Disability Living Allowance, so they wait a while for them. It would be good to meet a one off cost when needed.</p> <p>? It could be made clearer re other services and entitlements.</p> <p>? It would be an idea to help people to apply for advice and support, but difficult to monitor. Also to be careful with overlapping benefits.</p> <p>? Local authority assessments, also things such as Attendance Allowance, blue badge .</p> <p>? Needs to be fair and equal to all groups.</p> <p>? People could lose out on benefirs and services they could have.</p>
ONLINE68	<p>1) the biggest barrier is the obvious one. the disability. no amount of spin will affect that. when disabled one is just that. DISABLED it's in the name.</p> <p>after that the next obstacle is the governments insistence that we are second class citizens. a political football to kick around , using spin to humiliate us into submission. the cowards attack on people who can do nothing about it.</p> <p>that pressure leaves all of us in a state of fear and insecurity.this results in high levels of depression and suicide. it's bad enough being disabled without you lot making us feel unwanted and unworthy.</p> <p>2) i agree the system is flawed . "reform" scares us all. as the government , present and past, has no idea what to do. what you lot want is to get as many people off benefit as possible. the statistics out weigh the intention to help.it was a nightmare to claim before. it will be worse now. so nothing should remain as it is . WE ARE DISABLED.can you work that bit out. moving the goal posts every year only frightens and alienates us.</p> <p>3) travel costs are elevated.parking is now becoming harder to find and costs more. vehicle costs are higher due to the need for specialist or oversized vehicles. care from various people and institutions. to expect ones family to do it all is a pressure that is unreliable, unfair and a false part of the BIG SOCIETY.</p> <p>4) there are already two parts. any extra beurocracy will frighten people away</p> <p>5) of course . all permanently disabled people should qualify automatically. it's bad enough as it is without the pressure and humiliation of some beurocrat measuring by the millimetre. it is a scary experience to have to beg for life. there is no other choice for us. the only other alternative is euthanasia.</p> <p>how does one apply for voluntary euthanasia?</p> <p>6) by skimming the lesser needy , eventually there would be no one on benefit as the goal gets smaller and smaller. this is a loaded question and means nothing</p> <p>7) one is either disabled or not. medical technology may "fix " someone.the very nature of disability means they are permanently broken</p>

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	<p>8) again a loaded question. aids are increasingly being taken away from the needy. the less aids we have. the more we suffer so the more you will have to pay to pick up the pieces.</p> <p>10) the carer, the gp, the social service provider , the family. THE OBVIOUS.</p> <p>11) when the meeting is going to cause distress to the service user. fear will not change the individuals disability no matter how hard you try</p>
ONLINE69	<p>1) lack of understanding at school level to put in place the building blocks and equipment that are needed on a daily basis. Local Authorities, not providing as they should. Employees mis understanding that disabled people can be capable in other ways. Confidence of the disabled person who has received so many knock backs and challenges through out their life</p> <p>2) a tiering system, as disabilities effect different people in different ways.</p> <p>3) specialist equipment for personal use, social life promotion/help with, transport, accessing what ever the disabled person wants to as they should have life choices, this is assisted with money that the dla provides</p> <p>4) i would be worried if you were taking out the teiring system. it would leave many disabled people disadvantaged</p> <p>5) some conditions should have automatic entitlement ie blindness</p> <p>6) by asking what challenges they face day to day eating, socialising, computer access/training, holidays to get a break from the monotony, accessing social clubs and activities, healthy lifestyle promotion ie gym, swimming, music/drama activities. These are all things that anyone else can just access daily if they so wish, but if you are disabled they require alot of planning and input.</p> <p>7) listen to what the disabled person is saying. if the variabilities means daily life is very difficult, then award them what they need, not what you think they need</p> <p>8) it is often up to local authorities to provide adaptations and aids should be provided on the NHS. if these systems were working correctly then you would only have to top up for the things that are not already included in these two brackets. it may be better to make people aware of their rights instead. It is unfair on a disabled person to have to pay for additional resources out of money that they live on to help them access daily life</p> <p>9) we should be able to do it on line if we so wish, this makes it quicker and cheaper, being able to send in paperwork to support if required you should not quantify everything in minutes per day, as the different categories all cross over the current childrens form is better than it has been, but i have never filled out an adult form so can not comment on that</p> <p>10) gp, health visitor, consultant, therapist</p> <p>11) yes if assessing a child it is difficult for the parent to talk about the child if they are caring for them and tring to answer questions on the child. If the child is older it is inappropriate to discuss the childs issues in front of them sometimes, or indeed for adults. on the other hand they may then be able to see the difficulties first hand, but may not get answers to the questions that they have. It would be good if this person filled out the form for the person claiming instead</p> <p>12) yes there should be different types of reviews depending on the condition. Annual reviews in school work well, as it is a face to face meeting, rather than form filling</p> <p>13) circumstances can change daily when you are disabled, it is impossible to report all changes. a 6mthly email may work to help remind people</p> <p>14) if they are eligable, how to apply, someone who can do the forms for them, or at least help them fill them in. what they can spend the money on. a booklet or email would be fine with the option of a person to help if needed</p> <p>15) you would need to avoid expecting everyone to work as conditions can be so variable and dabilitating. if other areas of social provision were improved they would not be so reliant on this benefit. Employer awareness, job centers having proper training. Remember the disabled person and their carer are the experts as much as any professional, listen to them</p> <p>16) it should be through local authority funding and nhs this should be signposted. one off cost payments should be in addition to a monthly payment of money</p> <p>17) you should assist the children by assuring the school do provide appropriately and indeed the local authority should provide as well then this would not be on this form</p>

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	<p>?) there would need to be an additional sign posting agency</p> <p>?) not sure</p> <p>?) extremely important</p> <p>?) personal is fine but comprehensive is more important when drawing up the policy</p>
ONLINE70	<p>1) There are a number of problems/barriers that make it difficult and sometimes impossible for a disabled person to play a part in society and lead independent and active lives. Some of revolves around the amount of effort it can take to physically get ready in order to be able to leave the house. It can also be difficult to use the facilities available in public places outside of the disabled persons home. Often the facilities at home are 'moulded' around the disable person and 'fit the person like a glove.' Because of this it becomes difficult and sometimes impossible to use facilities in public places. Sometimes the disable person needs to carry a lot of equipment with them which makes moving around outside of the home a logistic nightmare. Public transport, whilst improving, is still not at a level for a disabled person to rely on fully. As a wheelchair user myself I need the confidence that, when using public transport, I can get on at one place, get of at where I am going and to then be able to make the return journey; at times this is not possible and thereby creates a lack of confidence in public transport. Additionally because of my dependance on my own wheelchair accessible vehicle the ever rising cost of fuel places an additional burden upon already stretched finances.</p> <p>2) The 'stepped' approach particularly the care element seemed to be a good approach for someone like me with a regressive condition where my care needs rise as time goes on.</p> <p>3) There are obvious additional costs that disabled people face - the costs associated with motoring, often the disabled person is reliant on their car to get them around and without it they would be restricted to their home or the immediate area. Clothing costs, particularly for wheelchair users, can be high because of the need for a particular type of clothing. Often the disable person can be at home for longer periods of time and need to heat the home and use hot water throughout the day. There can be additional costs in providing equipment and furniture to meet the needs of the individual. There can be additional costs associated with prescriptions especially if the disabled person does not qualify for free prescriptions. There can be additional costs for disabled people who own their own home and have to pay for minor repairs which they are no longer able to do themselves. There can be additional costs for shopping as often the best way to get the best price is by bulk buying but often this can put a disabled person at a disadvantage because they cannot cope with the weight aspect of bulk buying. Holidays can also be a problem as they need especially adapted places which can be more expensive.</p> <p>4) having just two rates per component, providing they were clear and understandable would appear to make good sense. However if all we are talking about is words then DLA could have been made clearer and more understandable. It would depend on who you are trying to make anything more clear and understandable to - often things that are understandable to government officials are as clear as mud to mere mortals like me. It would seem to me that the new benefit would need to be understood best by those who need claim it.</p>
ONLINE71	<p>1) we are unable to find jobs and are discriminated against by employers. as a disabled person who is also a father of a disabled son i was bullied by my previous employer until they found an excuse to make me redundant because i was unable to do the original job i was hired for and there were no other internal vacancies.employ is being dismantled so there are no chances for people like me, who have mobility and physical and mental health problems.also many of us, me included, would be housebound without our mobility allowance. and we are slowly being made that way by the increased cost of petrol. we need more help not less.</p> <p>2) it must be available to all british citizens and should be availableto all disabled who need it regardless of pension age. it must not go down.</p> <p>3) increased costs include motoring costs such as petrol, unlike you i can't just hop on a bike or stroll down to the shop. because i cannot walk unaided and even then only a few yards i have to drive everywhere. my heating costs are also higher as i am at home more and cannot keep warm by moving about. my medication, i have to have the internet in order to stay in touch and keep up with job hunting. i have no social life as i can't afford to go out.</p> <p>4) it does not take into account the levels of disability. it also takes no account of mental disability. i suffer from fibromyalgia which affects my mobility and my ability to use my arms</p>

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	<p>hand and shoulders. i also suffer from asthma, aspergers syndrome, mild tourettes and severe clinical depression. many people are tested by ATOS and deemed fit when it is obvious that they aren't, they are a private company who do not care about people, only their shareholders matter to them. i faced many doctors and a panel including a doctor, a lawyer and an expert carer. why could this not be done by my gp. you want to devolve the nhs budget to them but won't trust them to decide who is disabled or not.</p> <p>5) some should be automatic ie cancer, diabetes, kidney failure, spinal injuries that are severe. people are not treated fairly in this new idea. peoples gp's should be believed more. from the time i was told to claim by my doctors and my mental health professional to the time my claim was decided was eleven months. it must also be ensured that those who are already in receipt of DLA are not penalised by the new system. we need this money to have any quality of life. mentally ill people must be helped through this process as sometimes they are simply ignored and dismissed when they are just as in need of help as anyone with a physical disability. also it must be taken into account when people have more than one condition. for example my asthma on its own is manageable but in conjunction with my other problems it becomes a greater problem and debilitating.</p> <p>6) it should not stop if someone is in a care home, possibly reduced. how can a disabled persons family help them to have a life outside their care homes ie, trips out time at home with their families etc if it is cut entirely. they must be enabled to have internet access if they want it and can use it and must have the necessary technology to have a decent quality of life. it may be that it needs to be managed differently if the disabled person is not able to manage it themselves.</p> <p>7) conditions do fluctuate indeed and if someone gets significantly better and does not report that improvement they should be prosecuted and all money reclaimed and a prison sentence. however a man who is mentally ill and feels better today may be ten times worse tomorrow and common sense must be used. by the same token it should be made easier to tell the DWP if their condition worsens. my condition is fairly consistent but sometimes it lessens or worsens slightly and the depression i suffer varies sometimes over a quite long period lessening for a while and then becoming very severe. if gps were involved in the process this could be governed better.</p> <p>8) most people do not use aids until they are absolutely necessary, i believe that i may soon need to use a wheelchair but i'm fighting it until the last possible moment. it would be disgusting if you reduced a disability payment to someone who needed it, just because they could use a wheel chair. i find this idea not just cynical but a vicious cut at people who already at a serious disadvantage. it might help me get around but it would make my depression even more debilitating. also using a wheelchair creates its own set of problems. ie getting around shops using, public toilets and getting in and out of transport.</p> <p>9) shorten the form. this cannot be made to be a positive experience in any way i feel. if we emphasise the positive we are punished for it by atos. shorten the whole process and listen to our health professionals and stop assuming that everyone who claims are scrounging liars.</p> <p>10) listen to our gps. they know us best. i have seen 4 doctor's and many nurses, clinics, and carers and helpers during my disability. will you call them all in and interview them all. allow people to gather the evidence in letter form and submit it themselves if they are able or assist them too if they are not. the idea that the claimant should be interviewed by a doctor is already done. i faced a panel of 3 people including a doctor, a lawyer, and a highly qualified expert in care and i was interviewed and assessed thoroughly for an hour and i believe this is a good system. but i believe that, for those who are mentally ill they must be assessed sympathetically by qualified people as they tend to be intimidated by the process and don't get the help they genuinely need because of this and can fall out of the system leading to homelessness, drugs and drink.</p> <p>11) this could be a good thing especially if done in our own homes, they could see how many of us have had to adapt our homes to simply be able to manage. it might be inappropriate in some circumstances if the person is mentally ill and prone to violence. the disabled person should be able to have a carer or advisor present and the healthcare professional should also be accompanied.</p> <p>12) it should be reviewed every year by telephone or if requested by a doctor or health professional or by the proper authorities in person when requested. a genuinely disabled person like myself will have no problem with this. the idea that aids are so helpful is wrong the best they do is alter the problems encountered to a manageable level and slightly increase quality of life. this is just a excuse to cut at someone.</p>

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	<p>13) reduce payment gradually. and assist them to go on without the pip payment as this sudden reduction in income could cause them problems but, at the same time increase penalties for those who deliberately do not report improvements in their conditions.</p> <p>14) if we are out of work like i am help us to get jobs that we can do. if you intend us to use our pip money for anything other the things we use it for now ie. the money i get is used to pay for the extra heating i use and petrol and my motability car.</p> <p>15) help out the homeless and and mentally ill without them having to come to you. allow them to be refered by social services, homeless charities, doctors.</p> <p>16) yes. i will need to get an electric wheelchair soon and cannot afford to, i will then probably become house bound. stop looking for ways to cut us look for ways to help us.</p> <p>17) my son is also disabled and his condition is not likely to improve. he has aspergers syndrome and learning difficulties. he is unlikely to be able to hold down a job or live a day to day life without help, he is also vulnerable to people who take advantage. however you would not know this unless you knew him well. you would need to contact his school and his college and the riknel center to understand his needs.and listen to them as they are all professional.</p> <p>? ) as you have said put the benefits all together and cut the burocracy. but not the benefit.</p> <p>? ) if the pip was enough we might not need to be proped up by other passported benefits.</p> <p>? ) let us know what we are entitled to claim under this passporting sceme so that we can claim it properly and not over or underclaim.</p>
ONLINE72	<p>1) There are many disabled people who have unseen problems which are always over looked such as those with brain injury and autism. It is difficult leading a full and active life if you can't get SW and carers to really understand your problems.barriers include not knowing where to go and what opportunities there are for them. it is also about having the confidence to attend in the first place. Many disabled need a carer to get them from the house to an activity.Do many MPs and legislators really know what it is like to be a disabled peerson on a limited budget.to get my son to a simple activity like swimming takes 3 phone calls to his house.1, to remind him it is swimming day. 2 nearer the leaving time to make sure he has his money and trunks etc. 3 A call at the time he has to leave and to double check he knows his route.</p> <p>2) Serious financial implications.</p> <p>3) Extra expenses include heating costs because many disabled aren't good at budgeting. Shopping many disabled for a variety of reasons shop daily and locally where shops are slightly more expensive.</p> <p>4) It already sounds complicated. Mobility- please consider this carefulluy brcause it is not just a case of a disabled person being able to walk but actually having the ability to plan a route and catch ab us into town without problems etc. A disabled person may well be able o cok a simple meal but never remembe to turn the gas off.In trying to simplfy but cover all the whole process becomes messy and complicated.</p> <p>5) Yes but please look and consdier the more complicated conditions that are not always easy to appreciate unless you have experience of them, My son looks Ok, sounds very articulate but has tremendous problems and often doesn't know what day of the week it is, forgets to eat, forgets to wash etc etc. same can be said for thouse with autism and similar conditions. Science has moved on and diagnoses these conditions but the DWP and health authorities don't always regognise thee implications for the person.</p> <p>6) Whether the person is able to look after thamselves in the home.ie. get up physically or remembering to, person hygiene, physically or remembering to wash etc eating as above shopping or making arrangements to, travelling physically or abole to plan for and ability to access activities.Can they be relied on to take medication and organise replacment of tablets.</p> <p>7) Accept that some conditions do change or are likely to change but allow sufficient leeway for them to be as first stated. eg a year.</p> <p>8) No the fact a person has to use aids should be enough to state they are disabled and can't manage. Is the legislltion going to state a seriouly injured person who needs a lot of help from a carer but has a whellchair to get out and about doesn't qualify. Is a carer going to count as an Aid ? The fact someone has a Carer for 24 hours a day will the DWp say they don;'t need DLA because they are managing/</p> <p>14) A clear simple guide to completing the form. A whole range of people have to complete</p>

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	<p>these forms from the well educated to those who can barely read and write. Not everyone has someone who can help them</p> <p>?) Please try to ensure that any medical person assessing the disabled really understands the problem eg how many doctors know about</p> <p>?) Very although it is not always well advertised.encephalitis, have come across a case and appreciate the likely implications especially as the condition effects people in numerous differnt ways depending on which part of the brain has been affected. Similarly with hemochromotosis. There are so many conditions that effect people a Doctor can't recognise them all. If someone from ATOS doesn't have expeirence of the condition and its effects they should find out before dismissing the claim.Please make the form shorter. Most people have to take an evening or days filling it in.</p> <p>?) Council Tax Social Workers and GPs. Unfortunately communication between the various organisations is not good and often breaks down. Many GP surgeries you don't see the same doctor twice and often they are looking at different aspects of care. If my expeirence of communication between the different agencies is anything to go by the system although logical will soon breakdown Example of my experience GP says patient is lazy when nero pyschologist tests says serious brain injury in one part of brain.If asked by the DWP would both professions give the same report in respect of DLA? I think not. This is a difficult area that needs a lot of improvement</p>
ONLINE73	<p>1) The largest problem that i myself and others i know who are disabled encounter in society at large is that without a very visable form of disability more than we are capable of is consistantaly expected from the people around you. For example good self management may allow for short periods of 'normality' but just continueing one step further than is right for you can lead to disasterous relapses. this is not understood by many of the care profession outside their own specialities. in a general work or social enviroment often disabled people learn that unintentional bullying though a lack of education is still the most difficult barrier to overcome. I have personally found it essential to have the means to leave a situation as soon as possible at all times as my own disability is difficult to 'manage' and unpredictable.</p> <p>2) currently there is a set time for your claim to be considered and a response regarding your award. I belive it is important that there be a time promise seton this as the most vulnerable are those who arein need and currently waiting to hear back, often this is a time when they are struggling tocome to terms with a suddern change in their health or a frightening diognosis. while i understand that assesment needs to occur the period of time the individual has to wait and go without nessasary expenses can cause further health and social concerns/difficulties.</p> <p>3) often transport is an issue whatever disability. help with daily living that allows the individual to still dowhat they can does not nessasaraly mean care ie someone helping to clean the house can keep it managable so that the individual can still participate in a daily sense, help prepareing the meal might mean that the individual is able to cook when they are not able to do both. professional support in attending social activities can be very important. physical items of equipment that allow for some independance are often expensive. Being unable to leave the house often incurs the costs of high price online shopping or paying a shopper. Emotional health is a struggle for most disabled people but access to a counseler/therapist is expensive or incurs waiting lists of years through the NHS. Chronic and terminal illnesses often benefit from complimentary therapies like massage as management tools that facilitate pain reief and better management but these are again expensive or very long waithing lists. What each individual disabled person needs to pay for regarding these and many other points depends on how their own problem presents, what allows them to cope well enough to engage with others and how much available support they have as standard in their lives at the time of onset.</p> <p>4) having only two rates seems to be an over simplification of the assesment so far implied. You have stated that you find the current system to be 'vague' in its assesment i belive this would worsen the problem. I personally find this very disheartening as i know that either the higher rate can only be paid to those who are largely incapable of self care and those in the middle will recive the same level of help as those who have barely any need, or the higher rate will cover the middle to top end leaving the same problem. Being aware of the complexety of varieties of disability i find it totally unacceptable to formulate a system that has only three levels allowed for: no need;moderate need; high need. What about those that have moderate need if supported but become high need with only a few weeks without support? i personal would be offended to consider that someone who was to all intents</p>

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	<p>and purposes fine aside for having to have a wheelchair pushed was reciving the same catogary of allowance i was with much more complex needs because the only other option is pretty much confined to bed.</p> <p>5) If you discover that you have a disability that is severly affecting your ability to live a normal life being told that to get help you will have to wait half a year then prove that it will last yet another half a year is, in my opinion, actualy cruel. If your life is being significantly affected you are very likely to inccur significant difficties over all aspects of your life. By the time this waiting and proof and return of claim period is past their is a high likelyhood you will have lost your social connection, your job, your house and fallen into debt. I fail to see how this supports your agender of helping disabled people remain active in the comunity or retain their jobs. In fact i belive that it places a massive amount of stress on the already veryu difficult situation.</p> <p>I think that there should be automatic entitlement and follow up assesments to determine need at any diognosis or in any circumstance where the norm is that extra care will be required and disability has a high probilbilty of ensueing.</p>
ONLINE74	<p>5) I have Wegener s granulomatosis, hypogonadism, high blood pressure, depression, obesity.</p> <p>I have applied 3 times now for DLA and am genuine with my claim and very honest with all my answers, after walking for a short while 50 yds or so I have to stop to catch my breath also suffer with back ache and need to sit down. My low mood is due to low testerone that I am being treated for at the moment through the hospital. I am currently under 3 consultants at the hospital and my doctor has provided a signed letter to the dwp explaining my disability and how it interferes with my day2day living.</p> <p>My medication that I take is more than I would like to take and I sometimes forget what I have taken and in the past have taken them again.</p> <p>I don t understand how I am not entitled to this when there are so many who claim benefits that are just playing the system</p>
ONLINE75	<p>5) My husband has cerebral palsy. His benefits are granted "for life" at present. If his benefits are taken away or limited, that will be an injustice because his health will never improve and he will need more care as he gets older. How can this government justify that? They must have a group of lifelong conditions that are qualify for automatic benefits and CP should be one of them.</p>
ONLINE76	<p>1) I speak as a 57 year old, highly educated, experienced Human Resource professional, who in the last few years has been diagnosed with dyslexia and aspergers. I have spent a lifetime of distress at the negligence and incompetence of the government NHS and local services. One would think that in 2011 times would have changed but, Cambridge, the seat of learning, is way back in 1960s. I could write a book on the discrimination this sector recieve at the hands of the government of this country.</p> <p>The fundamental barrier interms of aspergers/autism is the complete lack of knowledge, skills and competency in the ability of NHS, local services and government services to even recognise a persons disability. Whilst the government passed the Autism Bill 2009 it has made zero difference. The government have made no effort to educate the public sector workforce and no effort to ensure that the local services provide diagnosis, assessment of needs and support to adults with autism/aspergers. The government state that they recognise that this sector of the community are the most disadvantaged in British society, yet there is nothing behind the paper documents. I am fearful that the government dose not yet fully understand the condition and its implications. I stand firm in stating that the most vulnerable, disadvantaged sector in Britain are adults with aspergers. There is an autistic spectrum and the key to support is the IQ. So if you have autism and an IQ of 70 and below the NHS and local services will provide support. If you have autism and an IQ of 70 and above, the NHS and local services say that they do not deal with aspergers. This is clear discrimination by the public services. This is the fundamental barrier, because until the public services accept this condition and the need for support how can the rest of society understand it. I have evidence of this, as Cambridge does not have an NHS worker who can diagnose an adult with aspergers. I was refered to Leicester Hospital, who confirmed the diagnosis and refered me to the mental health hospital in Cambridge. Their response was that they do not deal with aspergers and they do not have anyone who has the knowledge to do so. After 18 months of battling through the PCT exceptional case committee I had an assessment of needs from the private sector. The report recommended a referral to the mental health hospital which was refused again, a referral to social services</p>

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	<p>which was also refused, as they too do not deal with aspergers. Charities were also recommended but they too do not deal with aspergers. Counselling was recommended and I had to go through the exceptional cases committee again and they refused. Can you imagin the distress of all these doors slamming in my face. I was luck, as Andrew Lansley stept in and asked the PCT why they had refused and they quickly changed their minds and have given me counselling. There is no body in Cambridge who is taking responsibility for adults with aspergers. that has to be negligence.</p> <p>The government of this country need to recognise that autism/ aspergers is a life long condition and it is a life threatening condition. This is because of the lack of knowledge and support given and battles to constantly fight to get help which creates so much distress that the only peacefull avenue in life is suicide. In the summer of last year(2010) a medical student with aspergers at Cambridge University medical school committed suicide and in his letter he refered to the lack of support by the University. The University has a world renound Autistic Research Centre yet they cannot look after one of their own and cannot educate the local NHS or local services. What chance do we have in life in Cambridge. When you are fighting such battles to survive how can you participate in society? If the public really knew how this sector were treated they would be horified. But it is kept secret I think it is time for Panarama to step in and show the world how the government treats its people.</p>
ONLINE77	<p>in society.</p> <p>2)The support of social services is very slow, cumbersome and at times very unhelpful-basic changes in the home which would empower the disabled are hard to get, slow to be put in place and often poorly completed/thought out so that further visits are required. In our case it has taken almost 2 years to put a basic care package in place for the disabled member of our family and every step has required form filling, phone calls, emails and supervision by the main carer until completed. This is not only exhausting but has continued to hold back the progress of rehabilitation in every instance. At this point there still remain some basic home changes which would allow much greater independence and allow the main carer to leave the home to earn some money outstanding.</p> <p>3)Poverty caused by reduced circumstances prevents of full and active life. Both adults income was almost totally lost following a major stroke in our household, but this factor is common amongst the carers I meet and work with. One adult is sick and the other has mainly become a carer but attempts to maintain some work in an attempt to keep the family out of poverty. The impact of financial hardship on our children has been the loss of all extra curricular activities and school journeys giving them lessened opportunities for social interaction and physical activity. In the case of my son who is dyspraxic this has been particularly challenging as his physio is now carried out by me and his needs are less well met.</p> <p>4)Lack of funds has reduced opportunities to access services and support which would improve recovery chances and pain management e.g not being able to do additional swimming and physio because it can't be paid for.</p> <p>5)All stroke research indicates that physiotherapy is key to physical recovery- services are very weak in this area and poorly followed up on leaving hospital. After 2 years all services cease( if not before) and must be paid for privately by the family- this is a huge commitment financially at a difficult time</p> <p>6) emotional support- particularly for the disabled is poor to non-existent. Strokes are very strongly linked with depression and yet no services were offered in follow up in our area, basic counseling is an essential post stroke service. The impact of depression adds strain to family life.</p> <p>7) Support for carers is poor, adding to the difficulties of managing effectively. Many services are run in daytime hours and I can't work out how you are meant to attend when you are caring 24/7 for someone. respite is impossible for us as no service will care for the children AND the disabled individual. Therefore the carers is on call at all times.</p> <p>8)Services for younger stroke survivors were non-existant in our area proving to be a great barrier when beginning to meet needs outside the home</p> <p>9) sex and the disabled is poorly supported with few sexual therapists available and waiting lists long.</p> <p>10) Pain management has been poor- this has prevented therapies being completed and impeded recovery.</p> <p>In brief services are generally slow to respond, not broad enough in their remit or well enough targeted, families are left to suffer to the point of collapse before support is offered</p>

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	<p>causing anxiety/depression which compounds the difficulties. Poverty and poor support makes it very challenging for the disabled and their families to lead anything like a normal life. This of course is doubly compounded when it reduces the potential for the next generation- saved money for further study for the children has had to be spent paying the mortgage and adapting the home to meet my husbands needs. whilst have stated a personal position I know that our circumstances have been heavily mirrored in all carers groups across my area.</p>
ONLINE78	<p>1) Lack of integrated opportunities and not having individualised support on a regular basis to enable people to access/participate in the things that are important to them. 3) Transport costs if use of public transport is not an option</p>
ONLINE79	<p>3) Transport costs if use of public transport is not an option</p>
ONLINE80	<p>1) Society itself is problem and barrier. Access is inconsistent. Disabled people are not consulted regarding our requirements. I am frequently unable to access disabled toilets because I can't open the door alone, or can't get in in my powerchair. Shops are inaccessible, or if they do have ramps, they can't be requested. Attitudes to disabled people remain inconsistent and ignorant. Legislation does not help, because it leaves too manyloopholes.Modifications to homes are expensive. Aids are expensive. Services vary throughout the country.</p> <p>2) Why are you proposing to cease support at age 65?</p> <p>3) Adaptations to home - if not availablr through OT Mobility - aids, wheelchairs - I need both manual and electric - vehicle - although I do not drive, I still need the family car to be accessible; furniture - beds, chairs, tables, kitchen. Some travel can be dearer, as can holidays. I need to employ a cleaner. I am currently looking at remote control gas fire - cant light the present one myself. Heating bills dearer - most people who are less mobile feel the cold more. Help to access activities, transport, holidays, work.</p> <p>4) It may be more appropriate to look at three rates, given the range of problems thar people have</p> <p>5) all claims should be based upon the needs of the applicant, which would acknowledge that certain conditions affect people differently. However, the assessment process for the new benefit needs to be an improvement upon the curren one, which I found disrespectful and demeaning</p> <p>6) I find the previous assessment too simplistic. People need assistance to focus upon affording independance, and mental health and wellbeing shoul also be considered. Anynactivity that "able bodied" people regard as normal is essential! Very basics like getting up, wash dress, prepare and eat meal, plan daily activity, go out - whether to work or other activity, social activity and interaction, shopping, cultural activity, education.</p> <p>8) any aid or adaptation which raises a person's ability to carry out daily life should be considered. It's about levelling the playing field and equality of opportunity to take part in life! Aids people do not have but need could be crucial to improving quality of life.</p> <p>9) application process needs to be more flexible and less intimidating. current form is repetitive, and laborious and difficult to unravel. Plain english, brief questions, clarity about who can help people to fill in form.</p> <p>10) Carers' experience of the applicant could be helpful. Some "healthcare professionals" have no understanding of needs of disabled people. For example, my GP surgery has many consulting rooms inaccessible to wheelchair user!!! Other professionals who have contact with the applicant may be able to contribute</p> <p>11) Depends upon professional's knowledge and experience: healthcare experience does not guarantee knowledge of the needs of disabled people. I have found OTs most knowlegeable. Some may feel threatened by face to face interview - I have both positive and negative experiences.</p> <p>12) are you implying that use of aids may change an individual's needs? Remember, wheelchairs wear out, need maintenance and servicing, as well as insurance, as do sticks, crutches and frames.Special shoes are expensive, even with the VAT rebate. Some people,s conditions will be progressive - MS, Motor Neurone, Arthritis _ but will progress at different rates, depending upon the individual. Perhaps frequency should be decided upon in partnership with individual, GP, health, OT and Social service workers involved.</p> <p>13) I don't think stressing penalties is helpful - there are numbers of people who will be discouraged from applying for benefit at all. Perhaps claimants need agreed care plans</p>

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	<p>attached to the claim and review process?</p> <p>14) Yes, but at the moment this all sounds very paternalistic. Again, this could become a package of assistance, involving professional support as appropriate. Please do not assume that aids and adaptations are a "one-off" - as already stated, maintenance, replacement and repair is required - and annual insurance. People should also be able to purchase the best equipment for their needs, not just make do with what's seen as affordable. People providing advice and assessment need training - by disabled people!</p> <p>16) One-off cost not appropriate for aids and adaptations which wear out or break. I use my mobility to buy wheelchairs, and maintain, insure and renew them. And the Stairlift. And the gel cushions, cosy feet shoes, cotton soft top socks, etc. And actually, it's not really meeting the total cost! I have crutches from the hospital, shower stool, trolley, perching stool, bed rail from OT. I have paid for ramp to front door, raised toilets, rails, and bathroom conversion myself.</p> <p>17) I don't understand why eligibility differs with age. The most important thing is to encourage maximum independence.</p>
ONLINE81	<p>1) Lack of transport options and accessibility issues.</p> <p>2) Life recipients should be exempt from the changes - they have this award because they are not going to get any better and the current proposals only are causing unnecessary distress to this group. I have a hemi-pelvectomy and walk with the aid of a prosthetic leg and 2 crutches. I am only going to get less able as I age and my other joints cause problems. Why worry me about this.</p> <p>3) Travel costs and care costs eg heating is an issue and so is the cost of petrol</p> <p>4) It may be that it will be an all or nothing decision - the middle rate allows for more discretion and the ability to be more sensitive to an individual's needs</p> <p>5) Some should be - and this can be decided by professionals with the knowledge. Needs and circumstances change and the individual is not the best placed person to consider the totality of his/her needs over time. Research should be conducted to identify which conditions trigger automatic entitlement and then individuals assessed to be in that group should get it. I must again emphasise that the individual is not best placed to respond to this - certainly not at the beginning of his/her journey with disability</p> <p>6) Relationships Social inclusion Employment Recreation Time for self-fulfilment - arts etc</p> <p>7) Once again use research to identify the likely course of an illness and what remission might look like. Continually taking people off PIP and reassessing them will waste money and probably lead to a further deterioration in the individual's ability to cope with life.</p> <p>8) The use of aids and adaptations is a red herring. I have stated that I use a prosthetic leg and crutches to walk a shortish distance. On a good weather day I can manage this not too badly. But when it rains, is windy, snows and is icy - then I am virtually housebound. I am afraid it is not about what you manage on a good day that should be the determining factor, but what would you be able to do in any given situation.</p> <p>9) Tick-box with specific statements to reflect the information you wish to gather. It seemed like a guessing game to me when I first applied. This would also help less intelligent individuals find the right words to describe the impact of their disability on their lives</p> <p>10) Physiotherapists, social workers, nursing staff and medical staff are the professional people who know the person best and give objective but sound judgements on their ability to function in everyday life. Most disabled people are in constant touch with the above and you would do better to ask them for an assessment than train and pay an army of others to do it. It appears to me that the Government does not trust these people to do it properly (whatever that may) and therefore want to train their own staff. I wonder why the Government is therefore content to allow the GPs in England to run the NHS if they do not trust them to assess disability entitlements?</p> <p>11) As I discussed above - I am not against this but for the reasons above, I think this should be their own medical staff who know them best</p> <p>12) For life awards should mean what they say. For all other awards, depending on the research available, time limits should be constructed on the evidence.</p> <p>? ) Negotiate with GPs etc to book the individual in for a yearly check up and where such visits are routinely taking place, get the GP to return a form confirming current state of</p>

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	<p>wellness. ?) Keep Citizen's Advice to deal with this need</p>
ONLINE82	<p>1) The inability to perform everyday tasks. This can range from using public transport, travelling to and from shops/work, the ability to work, housework, cooking, dressing, washing, keeping the garden tidy. These tasks, need to be performed by all, if a person is unable to perform them due to disability, they have no choice but to pay for these services. 3) If they are unable to use public transport, disabled people have to pay to be driven places, ie by taxi. Especially in severe weather conditions. Disable people have to pay for all the things that they are unable to do such as cook, clean, gardening, window cleaning, decorating. They have to have connection to the internet so they are able to shop, either for food, clothes or household items. Everytthing that an able bodied person can do for themselves, a discable person has to pay someone else to do. 7) More reliance on GP and Hospital Consultants opinions 8) The fact that a person needs to use an aid does not automatically mean that this redresses the imbalance between an able bodied person and a disabled person. A wheelchair may enable a person to be more mobile, but it also means that they are restricted in their movements as not all shops/offices and public areas are adapted. A stick cannot be safely used in a crowded area, as people do not see the aid and are likely to impede the stick user, and many times they can fall over. If a person has prosthetic limbs, they are do not replace a natural limb. 10) GP and the individuals Hospital Consultant, who has long term knowledge of the condition. 12) Gp or individuals hospital consultant can give information and guidance on how often reviews should be set. They can also give information on whether the condition will get better or is degenerative. 13) Ensure people are aware that changes must be notified ?) Advice and support helpline should be available, but I do not think this should enforced ?) Clear instructions on completing forms and what supporting evidence would be required ?) The NHS supplied my adaptations for my home, but for a satir lift I would need to pay for this myself. Also I have had to pay for aids out of my own pocket with no recourse to additional support for this.</p>
ONLINE83	<p>1) Society's attitude towards disabled people 2) I agree with the things that will stay the same 3) Paying someone to take care of their personal needs e.g. toileting. Paying someone to support them to attend groups e.g. swimming, cubs/brownies etc. Extra petrol costs to attend medical appointments. 4) This seems good to me 5) Surely, if I person has certain conditions they would end up being entitled to the payment based on their individual circumstances anyway 6) Attending medical appointments. Getting to and from work. Getting to and from leisure activities 8) Aids and adaptations should be taken into account if a person has or needs them 9) The form is not to difficult to fill in, it is just lengthy. It is sometimes difficult to quantify how much time is spent doing tasks e.g. toileting. 10) A doctor's report after a medical. I was most surprised that my son did not require a medical in order for us to apply for DLA. It was useful that the SEN co-ordinator at school could complete a report about him, as she knows him well. 11) I agree with this totally. 12) A medical review with a professional every 3 years should suffice 13) If you write to people on an annual basis asking them to report any changes and ask them to attend a medical check up every 3 years 14) A list of things that people use DLA for. 15) Yes. At the moment some voluntary groups do offer this advice and support, but it should be statutory 16) Yes. I think some people use their DLA to do this 17) Children should have to under go medical checks too. If they are entitled to the benefit they should get it. ?) Very important. People need to be made more aware of how this system works. ?) It would involve more work on the part of individuals and those who administrate the</p>

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	<p>system            ?) DLA/equivalent, carers allowance, Blue Badge Scheme, Motability Scheme, energy subsidies            ?) DLA/equivalent needs to be available to children too.</p>
ONLINE84	<p>1) Disabled people are 2nd class citizen, we are kept in poverty and find it hard to manage to pay our bills. Not all of us are able to work and so rely on DLA.            2) Yes disabled people should not have to continually justify why they need the benefit, I have been told I will not work again and have a terminal illness, why should I have to prove to you I'm ill. I wish I was well but there is no chance of that. Leave me alone.            3) Medication, treatments, special clothes and shoes, bedding, heating, incontinence products.            4) just have one level of money for each level.            5) If a person is disabled and is currently on the high level they should be left on that level. being disabled and worrying about money is not fair. You have no idea what it's like to be disabled and poor. There are many illness that will not improve let people live lives            6) Money is the key give disabled people more money so they can make their own arrangement to do things and get people to go with them.            7) Conditions that can get better people need to be checked, conditions that are not going to get better people should be left alone.            8) All aids and adaptations need to be accounted for, if any others are need and can help they should be offered.            17) Any child that is helping someone should get carers allowance, also offer respite and support.            ?) Many disabled people are deeply upset by having to justify yet again why they need benefit. While some disgusting people claim when why don't have disabilities they rest of us are honest and decent people and are stressed at the thought of justifying themselves. I various consultants, specialist and GP's say a person is ill then leave them alone.            ?) very useful, the system works well as it is.</p>
ONLINE85	<p>1) Being unable to travel spontaneously because wheelchair users cannot be sure of the accessibility of public transport or whether transport providers will guarantee that they'll have a member of staff available to provide assistance. Even if you phone in advance to let the station/airport know of your requirements, they sometimes let you down. Taxi's are too expensive and some firms don't have large enough vehicles to take electric wheelchairs, despite changes in licencing the adapted vehicles can seem to be off the road more than on. Therefore the only realistic means of travel is to use a car with all the costs that incurs. Shops (especially in the high street)and other public venues must be made more accessible. Disabled parking bays on both public and private land must be properly policed/enforced to stop mis-use by able-bodied people and those mis-using blue badges. Employers (especially in the private sector) must be encouraged to stop discriminating against the disabled. Local authorities must be made to take into account the long-term requirements of the disabled person especially where it is known that a person's condition is likely to deteriorate over time. Because my local authority refused to take into account my individual needs, they have a 'one size fits all' policy, I had to use all my savings (accrued by saving some of my DLA over a long period of time) and increasing the size of my mortgage in order to get the bathroom extension and equipment suitable for my disability. The high cost of purchasing and maintaining aids and adaptations including car adaptations can also be a barrier for disabled people to lead a full and active life.            2) The Christmas bonus should remain because of the extra costs in travelling at this time of the year.            3) The main extra costs are:            1. Transport costs due to the lack of choice to use trains or buses. (i.e. having to use taxis or needing to use a car even for short journeys. This includes the running costs for the car, insurance and any adaptations or equipment to make the car useable/accessible.            2. Heating/fuel bills. The cold is a real problem for many mobility impaired people.            3. Aids and adaptations - high purchase costs            4. Aids and adaptations - maintenance, repairs and the increase of insurance premiums.            5. Having to take into account special dietary requirements.            6. Specially made clothing for ease for both disabled person and his/her carer            7. Assistance with personal care(e.g. washing, dressing, toileting).            8. Assistance with daily chores (e.g. cooking, shopping, laundry, cleaning)</p>

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ONLINE86	<p>1) My son needs communication support in order to participate. Most people do not know what support a dual sensory impaired child needs and when told may be unable to implement it, or may forget to, or may be unwilling to take the time to do what is needed.</p> <p>2) All applicants should be given the details of local organizations who can help them with the application.</p> <p>3) For my son it is equipment, cleaning materials for earmoulds to reduce ear infections, travel costs to appointments and for activities and trips with other deaf children. There are also the additional costs of weekly boarding including travel both ways (as the local authority does not pay for this) and the extra clothes and spending money necessary because he lives away from home during the week. In the past we have paid for private speech therapy.</p> <p>5) I think there should be automatic payments for more specified conditions rather than less. The current system relies on the parent to specify these needs in the application which means that the success of the application is dependent on the ability of the person filling out the form. Some parents are more skilled at filling in DLA forms than others, and some parents are aware that they can get someone else to help them and they know where to go to get that help. As a result some children may not get as much money as they are entitled to because the award is given in response to the way the form has been completed.</p> <p>For example, every child who is diagnosed with a significant hearing loss (ie, moderate, severe, profound or total loss) will need help with the same things including speech and language development, communicating with others, accessing the school curriculum and out-of-school activities, maintaining equipment (hearing aids, cochlear implants, radio aids), more supervision than their hearing peers to ensure their safety and more help with daily activities than their hearing peers because of language delay. Some deaf children will need even more help because they have other needs as well. If a deaf child has a parent who is not skilled at filling out the form and who doesn't know that they can get someone to help them, the child will probably be awarded a lower level of DLA than they are entitled to. At the other end of the scale, some parents are extremely skilled at filling in forms and gaining the maximum amount of assistance with any application or appeal. The result of this is that some deaf children receive a higher level of DLA than they are really entitled to.</p> <p>8) No. Taking into account the successful use of aids and adaptations suggests that they fix the disability. This is never the case even if they are used very successfully. For example, hearing aids can be extremely helpful to some deaf people and can enable them to access sounds that they would not otherwise hear, including speech. To say that hearing aid users can access speech is not the same thing as saying they can hear it in the way that a hearing person can. They will not hear it clearly or catch everything that is said (or even the majority of it). Hearing aids cannot filter out background noise or easily calculate the direction of a sound or access all the parts of speech in the way that normally functioning ears can. Hearing aid wearers will always need help to hear speech and will always rely on the patience and understanding of others to modify their verbal communication.</p> <p>9) Less repetition.</p> <p>10) From the professionals who are already involved with and know the disabled person.</p> <p>?) Children with a disability or long-term illness are likely to have many assessments and reports written about them by medical and educational professionals. These should be used when considering eligibility for disability benefits or services, and additional assessments should only be carried out if absolutely necessary.</p> <p>11) If the healthcare professional does not already know the disabled person they will need to rely on what the disabled person (or their parent or advocate) tells them and on reports received from the professionals who are involved in their care or treatment. This would suggest that a face-to-face meeting with a new healthcare professional is of limited value.</p> <p>12) It should depend on whether the person's disability or condition is likely to improve or worsen. For example, my son will always be deaf and partially sighted and will always need help to access speech and audio and visual information, and this will always have a significant impact on his daily life.</p> <p>For permanent disabilities or conditions the review should take the form of a tick list to indicate what, if anything, has changed.</p> <p>?) All children need to be cared for. It is important to remember that any additional care they require because of their disability or illness is on top of the care and supervision that they need anyway because they are children. Therefore, any parent who is caring for a</p>

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	<p>child with a disability or long-term illness has a very demanding role, and this is not always adequately understood, particularly by those who are caring for a child without a disability.</p>
<p>ONLINE87</p>	<p>4) Frankly, no. Two levels of support would serve nobody but the government in a cost cutting exercise. If somebody cannot understand the current system, then with all due respect to them, I doubt they would understand a two level system. It will save money, but for all other intents and purposes, it will leave claimants worse off.</p> <p>10) Medical services such as the NHS should be able to provide more than enough information to give a clear assessment.</p> <p>11) Face to face discussions would undoubtedly cause problems for some claimants, particularly those on the Autistic spectrum who would perhaps have many problems with social interaction.</p> <p>?) I cannot regard these proposals with anything but the the utmost cynicism. For all the word-play in the proposal document about supporting disabled people and equality, the entire document seems highly draconian and regressive for anybody suffering with a firm disability. The disabled are kicked down enough as it is, particularly in the current economic climate where the dogma of cost-cutting is everywhere. I have no faith in the DWP to provide any positive prospects for those it terms disabled. When the government's own members are routinely speaking of scroungers, the lazy and fraudulent claims, it certainly make for good headlines in the papers, but it also makes their intentions clear. It is obvious to me that despite this so called consultation, the DWP and government's mind on this issue has already been decided and it would be better for them to just come out and say it rather than pandering to the pretense of fairness and objective assessment.</p>
<p>ONLINE88</p>	<p>1) a lack of truly accessible affordable transport is commonly raised as a barrier by disabled people using local services. Also a lack of appropriate toilet facilities with a range of equipment ie hoist and adequate space for carers to assist those with more complex needs.</p> <p>1) truly accessible affordable transport is a consistent issue raised by people with disabilities as a barrier to social inclusion. accessible toilets with a full range of equipment available i.e hoists are at a minimum and many social venues do not provide adequate WC s to meet the needs of people with complex needs</p> <p>3) transport , support from carers to access activities additional to assessed care needs</p> <p>5) all claims should be based on needs and circumstances of the individual in line with personalisation, and moving away from a medical model that categorises people with a condition or illness. People vary in the way in which they manage the effects of illness / disability and an automatic entitlement could be viewed as a negative enforcement of the illness.</p> <p>6) the activities most essential for everyday life will vary from person to person according to their aims, objectives and lifestyle choice. The areas highlighted in the initial proposal cover the main areas , could work / education be included</p> <p>8) i believe assessment should take aids and adaptations into account, including those that the person may be eligible for or could reasonably be expected to use. Account should be taken however of the need to differentiate between the difference this makes to a person in their own home and when accessing activities in the wider social environment, for example, provision of equipment to facilitate safe moving and handling may be too bulky and unwieldy to use in a community setting limiting the persons ability to participate fully in a social/ work/ education setting</p> <p>9) focus on what the individual wants to achieve , their aims and objectives and the barriers that are currently preventing this.Avoidance of the view that in order to qualify the individual has to paint a picture of their worst day and emphasise their difficulties, a lot of people want to focus on what they can do and minimise their problems. Asking them how they would like their situation to improve may be a more positive approach focussing on possibilities rather than negatives. use of case studies to illustrate how people have used the benefit may help people to understand the qualifying criteria and use of the benefit</p> <p>10) if the person is known to health or social care professionals, these workers should be part of the assessment for benefit, current care entitlements should be considered and current assessments used as supporting evidence with the appropriate permissions.</p>

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	<p>11) it needs to be clear this is part of an assessment not an interview situation which is likely to cause distress to a number of individuals.</p> <p>12) a yearly postal review completed by individual and counter signed by GP or other appropriate healthcare professional may give an indication as to frequency of formal review required.</p> <p>13) in line with other benefits, there should be an awareness that failing to inform of changes which may make people ineligible to continue receiving benefit is an offence and is enforceable.</p> <p>16) in Derbyshire aids and adaptations are funded via Social Care or Disabled facilities grants. a one off payment to fund equipment not provided by statutory services but which would provide increased access to the community and social interaction would be very valuable ie provision of computer to access work / education sites, social networking sites.</p> <p>17) i think it is necessary to recognise play is an important part of a child's development and this element should be included as part of the qualifying criteria.</p> <p>reviews should be held more frequently than for adults to reflect ongoing</p>
ONLINE89	<p>1) the main barriers are ignorance of specific conditions that ultimately may scare employers away, the allowances/costs involved in dealing with clients with a range of disabilities (ie buildings etc) and the potential expectations that people, with certain disabilities, expect as a right/concession. All people, including those with disabilities, should be treated equally and without discrimination or bias.</p>
ONLINE90	<p>1) My son is limited by his lack of social awareness and his inability to pick up on social cues. This means that without adult help he is unable to mix with his peer group and can therefore be very socially isolated.</p> <p>6) Combining Direct Payments and DLA would get a better indication of how the payments should be used.</p> <p>Overweight people should not receive payments directly that could be used to increase their weight problem.</p> <p>In this case a payment could be made to an agency who could ensure that the disabled person accesses help and advice to combat their condition.</p> <p>7) Collect the views of the people that work with the disabled person, as everyone should continually be entitled to and access additional help and advice to cope with their conditions.</p> <p>Make a condition that the disabled people access help and advice on a regular basis from relevant professionals. i.e. if a person is disabled by their body weight they should access a Dietitian, Psychiatrist, and Personal Trainer to show that they are trying to improve their lifestyle.</p>
ONLINE91	<p>1) Lack of good public transport. Safe pavements. Lack of volunteers to accompany visually impaired people to places such as gyms for which sight is essential and staff are unable or unwilling to assist.</p> <p>2) People with a visual impairment use their DLA to purchase special equipment for use at home: particularly vital if they are out of work or coming up to retirement. And for children in order to keep up with their peers particularly in communication matters.</p> <p>3) As public transport gets less - particularly evenings and weekends - ALL visually impaired people are finding the cost of taxis impossible. We are unable to take part in evening classes and other recreational activities: and this is likely to be as true for those who are registered partially sighted as for those registered blind after dark.</p> <p>4) Those of us who have been eligible for 'long term' payments on account of having a disability from birth rather than 'acquired' could lose out under this rule. but in principle I agree two rather than three levels would be less confusing.</p> <p>5) Yes. One person's ability to adapt to any given condition will always be personal to them. Culture may also play a part as to whether someone would even apply: culture would continue to 'stigmatise' the person.</p> <p>6) Currently the DLA form does not cover the needs of the sensory impaired and we have to write long letters to make our position clear.</p> <p>Doing our shopping independently and safely.</p> <p>Being able to visit family and friends using public transport: many places do not have dedicated 'volunteer services' which are only available at specific times.</p> <p>For those using wheelchairs, accessible taxis.</p> <p>Taxi drivers fully trained in handling of assistance dogs with 'sticks' to make it work.</p> <p>Fully trained Volunteers - paid or otherwise - to go with clients to places such as gyms,</p>

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	<p>entertainment venues, etc enabling those with a sensory need to take full part in local life.</p> <p>7) By talking to the appropriate 'self help' groups who have an overview of such conditions as well as taking the view of the client.</p> <p>8) Yes it should. The partially sighted use a number of low vision aids in mobility and care situations which makes all the difference to their independence. In the case of the partially sighted: monoculars/binoculars, hand held magnifiers. Also the new GPS systems such as Trekker Breeze used by some visually impaired people both blind and PS. Sight can and does deteriorate and equipment is changing all the time. White canes are something of a stumbling block in the 'adventure' of losing one's sight and should be included.</p> <p>9) The form is too long, but it is also written with only those with a physical disability in mind: it is not fit for purpose for those with a sensory or learning or mental health issues.</p> <p>10) Input from the voluntary sector where such organisations exist as an 'overview' of a condition. Parents of children with disabilities as well as those caring/teaching them.</p> <p>12) Yes. In the case of a visual impairment, multiple visual impairments may give a different response to someone with only one visual impairment. Also a long term visual impairment is affected when a second condition materialises (eg senile cataract) thus leading to a temporary change, but then a different set of changes following cataract removal.</p> <p>16) In the case of the visually impaired the DLA is used to buy equipment and then to continue to up-grade it on a regular basis.</p> <p>?) Those with 'lesser impairments' would be less inclined to apply for any help and as their condition worsened they would still be put off applying for any help until it could be too late.</p>
ONLINE92	<p>1) Personal</p> <p>For me, with PPMS (Primary Progressive Multiple Sclerosis), it is the symptoms:</p> <ol style="list-style-type: none"> <li>1. Fatigue : this is crippling, and unlike ordinary tiredness (which it is not) it can take any or all of several forms. The bottom line is that if I am out anywhere, I cannot go more than an hour without resting, and after 2 – 3 hours at most, I must return home. After such an experience, I need the whole of the following day to recover. This prevents any kind of full or active life, and yet fatigue seems to be excluded from assessment metrics, e.g. those used by ATOS Healthcare.</li> <li>2. Incontinence : worry about location of toilets, and how long I may be out of reach of one, makes independence very difficult.</li> <li>3. Weakness and balance : being unable to walk more than a few steps (with crutches), and with poor balance rendering falls quite a common occurrence, confidence is dented and this makes going to any unfamiliar place something I am unwilling and unlikely to take on, especially in conjunction with 1. and 2.</li> <li>4. The day will inevitably come when I lose ALL independence and will need to be helped from bed, washed, dressed, toileted, fed, etc. Already I find it difficult to get into bed at night, and to dress in the morning. Washing and eating are also increasingly difficult.</li> </ol> <p>General</p> <p>These apply to me, but also to everyone with a disability.</p> <ol style="list-style-type: none"> <li>1. Attitudes of people in public. These can range from sympathy accompanied by incomprehension of the 'right thing to do', to outright hostility, in part fuelled by media outlets such as The Daily Mail tendency to brand (at least by association) all disabled people as 'workshy scroungers'</li> <li>2. Public infrastructure being often inadequate : for every disabled parking space, there is a concomitant inadequacy, especially in the provision of public disabled toilets.</li> <li>3. The fear of 'ordinary' people that ranges from 'I might catch [whatever it is]' to 'I don't know what to say or do' types of discomfort</li> <li>4. 'Does he take sugar?' Even the Social Services are not immune from speaking down to someone who is PHYSICALLY disabled, when there is nothing wrong with their mind!</li> </ol> <p>2) Apart from the initial form (which I assume is as it is, in order to make fraudulent claims more difficult?), I cannot see anything about DLA that needs to change. It is not means tested, and is available to a disabled person whether in work or not, and therefore is a fairly assessed benefit at present. It recognises the extra needs of people with disabilities, irrespective of their financial and work circumstances. It is 'fit for purpose'.</p>

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ONLINE93	<p>1) The DWP is already well aware of the many issues experienced by disabled people, it is beyond belief that you should be asking this sort of question at a time you are considering removing hundreds of thousands from receiving DLA. How can you even suggest an objective test for disability when you need to gather such basic information as this. This website is an example of the barriers, as is this consultation, accessing this page is beyond many disabled peoples ability, your short timescales for this consultation are a disgrace.</p> <p>2) The ability to give a personal view of how disability affect the claimant is a vital component of this benefit, it allows the claimant, the one person who does actually know how disability impacts on them, to give a realist account of the support they need. It is not acceptable for another person with little knowledge of the individual to take over that role.</p> <p>3) Again, as a government you know the answers to this question, why is it being asked here?</p>
ONLINE94	<p>10) If a customer is visited by any health professional they(the customer) should be asked to provide identification proof.I have been a DM and have heard of people fraudulently claiming DLA for a disability they do not have and when an EMP visited they ensured that someone with the disability was around their house when the EMP came round.</p>
ONLINE95	<p>1) The social model of disability affirms that disability results from the barriers created by the environment, people's attitudes and organisational policies and inflexibilities. However, the other barriers are just as important, if not more so - the disabled person's view of themselves and their capabilities and the actual difficulties created by the disability/ies. I have met many disabled people who think they can't work because of their conditions. In my case, I have rheumatoid arthritis and Meniere's disease, which together have made me deaf, given me tinnitus, cause major vertigo attacks, led to many surgeries, given me serious deformities in the hands and wrists and caused lots of pain and suffering. But I have worked full time since 1987. Those people who believe that their disabilities have ruined their lives and made them unemployable need active help and support to change their thinking and help them to a fuller life. A good and effective benefits system needs to provide both where needed.</p> <p>2) One of the aspects of DLA worth retaining is its split into just 2 components. Its ability to contribute towards a vehicle or powered chair is also valuable. A wider definition of mobility is long overdue. For example, I can't carry anything due to the damage done to my hands, wrists and shoulders by RA. Even on the days when my knees are less painful, walking to shops is not possible as I can't carry anything back. So I use the car for shopping trips.</p> <p>3) I can only comment on the extra costs I experience. These would be: having to make additional trips to pick up stuff I can't carry in one trip; buying thermal underwear because I chill so easily; keeping central heating on for the same reason; needing help to do my hair/dress etc; restrictions on what I can wear due to difficulties with buttons etc; needing to use taxis if the car isn't available; replacing crockery etc due to constantly dropping things as a result of my poor grip; purchasing aids and adaptations etc. There are other, less visible costs, like not being able to take advantage of bargain buys (for example in shampoo) because they tend to be bigger and I can't hold them. Or dropping cash as I try to manoeuvre it into my purse!</p> <p>4) As long as the greater simplicity doesn't result in people's particular needs being squeezed out. One of the benefits of a more complex structure, as in the current benefit, is that it is more able to accommodate a wide range of disabilities and needs. Simple schemes tend to be 'either/or' and exclude people by virtue of becoming less flexible and graduated. People may not like the complex claim form that the current scheme requires, but it does enable individuals to supply a lot of detail about their condition and its effects. This detail should in turn enable better decision making by DWP - the fact that it doesn't appears to be the result of a less than clear scoring and decision making framework. Seems a shame to throw out the baby with the bathwater! At work I am involved in evaluating ESF bids. They have a clear scoring framework - each bid is evaluated separately by 2 people, then moderated by an experienced adviser. The results are then viewed by a separate panel, that makes the final decisions. There are clear scoring criteria and guidance. Why can this approach not be applied?</p>
ONLINE96	<p>1) There is a natural discrimination against people who look disabled, as if it might be catching or is somehow disgusting.They are regarded as and made to feel inferior. There are physical difficulties for the physically disabled eg getting onto buses etc. However</p>

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	<p>nowhere in these discussions have I seen a distinction made between people with a physical disability but of sound mind and those who are mentally incapacitated, who may never manage to live independantly.The two are very different.</p> <p>2) DLA should be awarded according to need. Many people are frightened that even though they have need, just because another has even more need, they will be denied the help altogether. This cannot be just or fair.</p> <p>3) I am speaking as a parent of a child on the autistic spectrum. My son't DLA is spent on extra clothing because he gets very dirty, shoes becuase he is very hard on them, renovating his room when he wears through the carpet due to rushing from end to end across the floor and wears holes where he skids to a stop, replacing plaster on the walls when it is worn through to the brick because he puts his hands out to stop himself. It pays for respite days and travel incurred with that and if there is anything left, it goes towards the hot water bill because once my son gets into the shower he stays there for twenty to thirty minutes or until the hot water has run out.These are just a few of the areas the DLA helps with.As far as independant living costs - he will need a PA to help him get out and about when we his parents are too old to do it.</p> <p>4) I don't think the above will be adequate at all. The government may want to simplify things but disability is a complex issue not least because every individual is different. The above system risks chopping out people who should qualify and at the same time overpaying others.it is way too clumsy. I think a points system would be a lot better, and payments can be made on a sliding scale accordingly, and reassessed to so that small adjustments can be made rather than people suddenly losing all their benefit at once just because they have improved slightly. I think this would be much more efficient and could be taylored to the individual a lot better and not necessarily more complicated to make work.</p> <p>5) Difficult to know, but there needs to be a comprehensive list of recognised conditions that are known to cause additional need so that the individuals concerned aren't faced with a huge fight to prove their needs. Individual circumstances can make a lot of difference and need to be taken into account.</p> <p>6) One must ensure that an individual can satisfy basic needs for life - buying and preparing food, clothing, keeping clean and a roof over their head. Also they must be able to access social contact by getting about.</p> <p>I speak as a parent and carer of someone on the autisitc spectrum. This group have been appaulingly badly provided for in the past. The condition is complex and individuals affected suffer to widely different degrees.Training of professionals and social carers in this condition is vital. A person with ASD may have a significant learning disability but also be gifted in one particular field. So they may have achieved a PhD in one subject but not be able to use public transport or to cook a meal or to manage their personal hygiene needs at all, or be able to make friends. This should bracket them as having a significant learning disability. Society needs to support their failings but also facilitate these people so they can also work and allow their strengths to be used. A more flexible system is needed - a points system, not one that sorts people into convenient boxes.</p> <p>7) Assess each individual and award them benefits on a points system which is more highly refined and targeted. The current system is a blunt one.I'm not sure that fluctuations can be targeted unless there is a system for taking people into care when they are very ill.</p> <p>8) of course the assessement should take all those things into account. In some cases an aid will be all they need to live independantly, in other cases it won't.</p> <p>9) I don't find the claim form too complex, but it is far too long and requires you to repeat what you are saying over and over again.It is also annoying for those of us who care for learning disabled people because it is mostly concerned with physical disability and so is largely irrelevant in my son's case. I also recognise that without me to fill in the form, my son would be unable to accesss benefits - he wouldn't know where to start or what to do. I find the prompt notes helpful because when you first fill in the form you have no idea where to start or what is being looked for, or how much it's necessary to say.A lot of people don't explain their needs fully because they assume knowledge on the part of the assessor - that they must know what problems they are experiencing with their condition.</p> <p>The more information you can give about PIP the better for those truly in need - many people are very frightened that they are going to be cut off simply because the government want to save money - it's very worrying.</p> <p>10) For my son who has Aspergers and therefore autism, going for an interview with someone he doesn't know would be hightly stressful and he probably wouldn't say much. I</p>

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	<p>frankly find the idea of having my son's case assessed by someone government'approved' highly intimidating and a little insulting.I would be highly suspiciuos that they would not be sympathetic to my son's case in the interests of cost cutting and doubt whether they would know anything about autism whatsoever as we find most of the time when dealing with 'professionals'. I would be much happier if we could be assessed through our GP. I note that so far in these discussions parent carers have not been mentioned in terms of expertise on their childrens needs - we are more expert than anyone else, and should not be dismissed in favor of 'professionals' who usually know nothing!You must get information from the people who know the disabled person well, especially where there is mental disability as the person themselves cannot usually tell you what you need to know.</p> <p>11) I have half answered this question in no 10.I would demand that whoever the health professional was involved in discussions, they should have a very thorough knowledge and understanding of autism, and have spent time living in an environment with several people on the spectrum. Only then would I feel they truly knew what they were talking about.Having been on a course or having read a book would not be enough training.It is a very complex issue.</p> <p>For most people affected by autism, having a face to face interview with a stranger is extremely stressful and many would simply not be able to tolerate it. From my point of view, having to discuss what my son can and can't do infront of him would be humiliating for him. I fill in the forms and go through them with him as he has to sign them now he is over eighteen but this is very upsetting for him as it is. He understands he is disabled and has very low self esteem. Rubbing his nose in it would be inappropriate and disrespectful to him.</p>
ONLINE97	<p>1) In my experience there are times when one's disability can be more difficult to cope with than at other times. There are times when one can appear to be well in the fullest sense. At these times many people would like to engage in paid work. However there is a lack of flexibility in the current system which means that benefits can be withdrawn if a person engages in paid work for any length of time. This acts as a dis-incentive for the disabled person to take those all-important steps to independence. There are also times when a disabled person cannot fulfill the responsibilities of paid work and needs financial support. I sincerely hope this same mistake of penalising attempts to return to work by withdrawal of benefits will not be made in the revised system. It would be most foolish not to make the system flexible in the fullest sense of the word. In this way a person can be supported in their endeavour to lead full and active lives. In the long term this would also be far more cost-effective as I am sure you can see.</p>
ONLINE98	<p>1) The lack of employers understanding of individual disabilities which they should understand the basics of the staff who are disabled and their disabilities nature. I have Multiple Sclerosis and on a daily basis even though I am a Deputy Head Teacher who still fully works within the school I cope with not always visible disabilities one day I may have balance issues so I teach and work with my stick, the next day I can have extreme muscular pain and medicate myself but complete my work fully without alerting all to my every change. I have faced since my diagnosis a complete by passing of my abilities as soon as I was given the diagnosis another assistant head was employed and my head without any advice immediately put me into resticted duties even though Occupational Health are completely fine and support my ability to work and my work has in no way deteriorated or lessened . I have been effectively put into a special bubble even though I have been told that I have been suffering for 10years with this disability but as soon as it was confirmed it is an immediate excuse for employers to use it as a weakness and isolate individuals. What has caused my biggest barrier is my exclusion from the role I have been working in for the last 9 years at the same school under the same Headteacher, she feels unable and has stated that I can not be trusted or am capable of the work even with no evidence and still I get excellent results from Ofsted and my work is always of the highest standard. I also have an excellent health record and have usually 3 days off ill per year or less. So it is others using the disability for nefarious reasons not always openly that impact deeply when you are already fighting not only your own body but others designs. Too much discrimination against labels and as soon as an employer hears on any paper even in their own work place they will face immediate discrimination- all that is seen is the disability not the person and the hassle it will cause-time of, equipment and people immediately start to think that your brain is effected-talking down to you or excusing you or worse highlighting you as their token equality ticket. I feel that nobody is to allowed to know of a disability</p>

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	<p>unless the individual is wishing to share it. The more information that is given to employers especially the lack of employment and interviews will be given and independence achieved.</p> <p>2) The basic questions should be more detailed other than stating what help you need at night. The breakdown into smaller questions that can be specific to all disabilities. More information on the disabilities that like my MS are extremely changable on a daily basis these disabilities are the ones that will be the most difficult to fill out eg one day I can be using 2 sticks another I look fine but my vision is blurred and all different changes that a nerve ending can make, vomiting, dizziness and confusion as well as word / memory problems. Theses are so much more difficult to answer and certain conditions will not be so easily boxed- in you need to tell about changes in your condition I would never be of the phone and there are many conditions like MS such as Fibromyalgia how do you test for pain levels and an individuals ability to keep going as all disabled people do-we dont tend to shout how we are feeling every day. This will be the most demanding area to support through legislation and benefits.</p> <p>3) There are so many and so different objects needed from extra pants to wheelchairs ramps and specialised cars. There is also the burden on others to transport, help in the household which usually falls to family members. trying to get insurance, holidays/respite. Visits to specialists, getting medication and extra items of dietary needs clothing, access to the internet is a huge importance and that is costly so costs are extremely difficult and individual as well as changable depending on the disability and the individual. Most disabled people have houses that they work to pay of a mortgage and support for when certain disabilities deteriorate need to be addressed-because usually by then you cant get any of the special insurances unless taken out well in advance of you becoming disabled and no-one ever thinks that will happen. Support for the families and children of disabled people needs to be addressed this you can only work 16 hours to claim attendance allowance is shocking as these family members pay all their taxes and will still carry out huge amounts of support and help at home with their disabled partner. Education for children of disabled parents should be free at college level as during their lives they care and work and if they manage with the burden of education and living with a disability or helping a disabled parent they should be given as much support to enhance their lives as they do not get paid for the extra work they complete in a disabled house each and every day.</p> <p>4) I feel that both should have 3 low, middle and high. With just two its either your just disabled or completely so 3 is a fairer separation.</p> <p>5) There are certain disabilities that should be automaticly given entitlement especially chronic and degenrative disabilities, this doesnt mean that every disability should be covered but we are now at a stage to understand from medical and groups which conditions are in these categories, cancer until remission, MS, Parkinsons, Alzhiemers, Motor Neurone Disease, Crohns and many more all are within this category. The need to look specifically into the disabilities that are difficult to prove and the lengths that an individual has gone to to get help and support for what they feel wrong will also be a good way to check the validity of a disability that is not able to be physically proven. I know of 2 people with diagnosed Fibromyalgia 1 was taken to court over a malicious tip off even with complete backing of her specialists and doctors she is still unable to receive DLA and a newly diagnosed one who is scared she will not be believed but has spent 2 years going through a multitude of medication and various specialists to reach this point should be included. I get angry with people who are allowed to claim disability without attempting to get help as in the depressive and anxiety disorders it should be part of the conditions and self induced disabled people the smokers alcoholics and addicts they are not disabled they have to be looked at in a completely different way. Especially if there is a history of refusal to take up support advice and aid.</p> <p>6) Using a 3 tier rating system and prioritising from there. Also specific training physical training of professionals in carrying out eavery day actions with a'fake' imparement eg making a basic meal with your main hand tied to your side, being told to retrieve an object without knowing the object needed. There are hundreds of various senarios that will help students and professionals even remind them of the everyday difficulties. Then they need to be LISTENED to what do they need what is important to them there can not be a one size fits all.</p> <p>One family it might be once a week a day where the disabled person is taken care of. There also has to be a close look at the individuals resilience and resources some could be</p>

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	<p>completely alone with no support which means social contact is prioritised this could be fed through professionals to charities and organisations working within the areas. Listening to also the disability organisations that are constantly being asked questions and they know where support is being asked for. 7) Many disabilities can be stationary but there is a large number of disabilities that like mine MS fluctuate daily. It has to be based on worst case scenario of the disability as if it has happened and changed badly before it will again. Overall if professionals have given a diagnosis the state must follow the response. If you have Alzheimers you and I know where this will go it is only time that changes not the outcome and the support needs to be full and comprehensive to cover mental health issues on diagnosis to support all the family so its not wasted money it is priority to the family at a critical momment.</p>
ONLINE99	<p>? ) Information on support needs to be provided by healthcare professionals as a matter of course. This would open it up to the whole community. ?) It is absolutely essential. My DLA proof entitles me to my Freedom Pass, Blue Badge, Motability car, CEA cinema card, an essential carer at several organisations, a Disabled Person's Railcard and numerous other things. Without this, I'd have to be assessed over and over and over and over - taking up NHS time and mine. To make it easier, the Department could inform local councils of an entitlement, and arrange automatic sending of appropriate applications for transport passes, Blue Badges, contacts for Social Services etc. ?) It would be a logistical nightmare. Service providers would pull their support as it wouldn't be manageable. That, or they'd end up charging disabled people for proof. ?) PIP should be linked to Attendance Allowance, Employment and Support Allowance, Disabled Students Allowance, Council Tax reductions, Blue Badge and Freedom Pass/Bus Pass applications, as well as social care assessments. All could be covered in one! 2) When a medical condition is ongoing, and unlikely to ever change, such as a long-term disability (like Cerebral Palsy), indefinite awards should remain. Reassessing when it's not going to go away is a waste of resources and a source of undue stress for disabled people like myself. By constantly reassessing a condition that will never change, it makes me feel like you are accusing me of faking, or will tweak the rules to try take my money away. 3) Mobility is a key one - put simply, where most would walk, I'd have to get a bus or a taxi. Where most would take the tube, I'd have to take taxis to avoid escalators. These costs really add up, and without support, I'd simply not be able to get around. DLA currently gives me access to a car, with motability, which means I can have a much greater freedom. Taxi's won't go for short distances that are further for me to walk without pain. Some other costs occur, that you might not think about. For example, I often have to pay delivery for online shopping as I can't carry groceries. I also have to buy pre-prepared food, rather than raw vegetables, for example, as I'd struggle to peel and chop. This is more expensive to do. I have had to buy certain items of furniture to assist me using a bath. All this, and more, adds up to a much more expensive life 4) The issue with only 2 rates is that it leaves it very black and white. For those who fell in the middle ground - are they automatically downgraded? How will that impact their independence? 6) Freedom of travel, shopping, cooking, washing and bathing, communication and many more. 7) You need to treat everybody as if the worst days, not the best, are the standard. The person should have enough support to cover them if every day way a bad day - otherwise they could end up in trouble. 8) Aids should not be taken into account, if they are still going to make life harder. A person in a wheelchair who can cover a certain distance, will not be able to do so as easily, and on the same methods of transport, as a person walking. Potential aids should definitely not be counted. It's impossible to say if an aid will ease or hinder a person's independence until they use it regularly. The government should not be dictating what aids and adaptations an individual should use in order to take away their funding. The financial support is there to help the individual make their own decisions about how they manage their condition, and what adaptations they choose to make to their own lives. It should be about enabling choice, not restricting it. 10) An occupational therapist with expertise in the individual condition, backed up by medical record.</p>

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	<p>12) The initial assessment should be able to establish if it's a condition likely to change or not. If it is an ongoing condition that does not improve, such as Cerebral Palsy (the affected parts of the brain are dead and will not grow back), then the award should be indefinite. Reassessments are a waste of resource and a source of stress for the individual.</p> <p>14) Motability should definitely be introduced, as well as how to go about applying for Blue Badges and disabled transport passes, as well as disabled railcards etc. Sources of information such as how to apply for a social care needs assessment for adaptations to homes etc. Charities and support groups such as Scope, are a useful direction to point people in. Other related things that may be entitled to, such as a reduction in Council Tax for those with adapted homes, Disabled Students Allowance etc. A list of organisations that provide specific schemes for disabled people - e.g. CEA card for cinemas etc.</p> <p>15) Definitely should not be a requirement, if it's to encourage independence.</p> <p>16) I use Motability which is a great scheme. I also used to pay for a cleaner. I do agree that there should be an option for it to meet a one-off cost, for example a wheelchair.</p>
ONLINE100	<p>1) As a mother of a child who is a wheelchair user i would say there are not enough clubs or groups that encourage disabled children to participate. Usually the clubs our children attend are specifically for disabled children.</p> <p>2) possibly cancer patients who are not terminal should be considered for dla short term?</p> <p>3) Personally my main cost is adaption that are not covered under the grant scheme and equipment that is not available via NHS. Also my son bottom shuffles and so he can get through quite a few pairs of trousers a year!</p> <p>4) I do think this is a better way of assessing a persons need. The old system was difficult to fill in especially the how many times a night do you have to get up to your child and for how long each time etc, too time consuming and it would be easier to write what you have to do for your child or yourself on a daily basis than answer questions in that format.</p> <p>11) Personally for me i would prefer someone to have a discussion with me as the health care professionals that are involved with ████████ do not know what i have to do for him at home as they are not involved with him at home. They could give a health and what he is able to do/not do but they would not be able to give a accurate assessment of what he is or is not able to do at home.</p>
ONLINE101	<p>2) access to the motability scheme should remain in place</p> <p>3) - maintaining mobility both within and outside the home is an additional cost e.g taxis or use of a car instead of being able to make use of public transport, aids to climb stairs. - additional support and help in the home to assist with routine domestic</p> <p>4) having two rates per component will make the benefit easier to understand but it is impossible to say that this will ensure appropriate levels of support. There will always be difficulty around the thresholds and many individual cases which will not fit within a standard assessment. This difficulty might be alleviated to some extent if there are ranges of need described within each segment of each component so that a judgement can be made in each individual case. In cases where there is a combination of needs in the upper ranges of the lower components then this may be taken as an indication that a higher level of award is needed.</p> <p>5) some conditions, such as MS, are incurable at present and have a degenerative effect over a lifetime. The impact at onset may not seriously impact lifestyle and mobility, although there are unpredictable periods of relapse, which have a very significant effect. Perhaps the best approach would be to build in a greater expectation that those who suffer from such conditions would be awarded the benefit, though it is difficult to see how an assessment of each case can be avoided.</p>
ONLINE102	<p>1) Disabled people encounter problems and barriers from the earliest age. They have unequal access to integrated childcare, schooling, colleges and universities. They therefore start in life, in the main, with poorer educational achievements and lower levels of socialisation. They not only face physical barriers/lack of sign language interpretation of lessons and other activities such as sporting activities, volunteering opportunities etc, all crucial for socialisation and employability. Disabled people have reduced choices in terms of housing, work, leisure and fitness, etc, leading to much increased chances of living in poverty, suffering from ill physical and mental health and of lower life expectancy. People with reduced mobility face the double barrier of getting to and then using facilities. Ensuring that they have a flexible means of independent transport is the first key to ensuring they can train and work as well as make use of health, leisure and fitness</p>

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	<p>facilities/provisions. This applies, whether or not the person has a wheelchair/rolator etc. The wheelchair or the walking aid enables the person to move about their home and possibly their local neighbourhood (if the local pavements, schools, amenities and shops are appropriately laid out). Commuting to work or to college during rush hour is a very different thing. Many disabled people cannot walk and/or stand in a queue for any length of time, even if they have a stick/crutch and therefore could not get to the bus stop/the station etc.</p> <p>A person might be able to wheel very easily on flat, smooth surfaces but not up any hills or up/down curbs which are not consistently lowered. Therefore, though someone might have a wheelchair already, this does not necessarily remove the barrier to their independent mobility. An electric wheelchair may be the solution to this but may not fit in their home, let alone on the bus or in the lift at work etc therefore pushing someone to use a powered wheelchair could reduce rather than increase their independence. For a large number of disabled people, their motability or DLA funded car is the absolute key to their independent, full and active life.</p> <p>2) The fact that it is not means tested. The fact that if the disability is known to be for life, no review is required unless the client requests an increase. Making regular reviews mandatory in all cases will be very costly as well as create high levels of unnecessary stress for people whose conditions do not ever improve.</p> <p>3) Extra heating bills; Extra transport costs from often not being able to use public transports, either because buses, tubes and trains are not sufficiently accessible or because the person cannot get to/from the bus stop/tube station/train station unaided. Disabled people incur extra costs from often not being able to shop in the cheapest places. Many disabled people are in fuel poverty and cannot access the cheapest deals due to not being able to pay online or by direct debit, even though they often have increased heating needs due to inactivity and much time spent at home. Disabled people often need facilitation with shopping, cleaning, laundry, as well as help with personal care, parental care, etc. These are chargeable by their local authority (if they are dependent enough to be eligible for local authority support) or has to be purchased privately until they reach the eligibility level. Disabled people are often reliant on a car/van for all travel outside the home and are experiencing constantly increasing petrol costs. Though the DLA has provided funding for a car, often through Motability, disabled people's ability to put petrol in it has been eroded steadily over the years; Where they do not own a car, they have to rely on taxis where local community transport schemes are not sufficient or sufficiently flexible or responsive (for example to accompany children to/from school, to attend GP/hospital appointments, to visit swimming pools, to get to job interviews, to get to work etc.). Disabled people often require bespoke clothing and/or need to replace clothing/footwear far more often than non disabled people. They must have the right footwear and access to flexible podiatry services to avoid being immobilised and loosing their independence/their jobs etc. Where these are not adequately provided or provided at all, disabled people incur high extra costs to purchase these privately. People undergoing intensive medical treatment (such as chemotherapy or dialysis etc) must not only be available for the treatment (and therefore unavailable for work, leading to poverty) but they also incur the cost of additional childcare, transport, support with shopping, preparing meals etc.). Disabled people often struggle to eat balance diets and often need to purchase food supplements. They also often rely on complementary treatments such as massage, acupuncture, as well as hydrotherapy, regular, intensive physiotherapy etc which are rarely available on the NHS. When disabled people purchase a car or a bike, they generally need additional adaptations and generally need to purchase higher costs vehicles/equipment (automatic cars are pricier to purchase and are generally only available at the top of a range; trikes are a lot pricier than bicycles etc). Disabled people are also reliant on many aids and adaptations, many of which are not provided by local authority OT departments and DFG grants are means tested, leading to many disabled people needing to pay for crucial adaptations to their living environment.</p> <p>4) Though this might make it simpler to administer, reducing the number of rates will make it more difficult to ensure the right level of support for people as it will inevitably be very difficult to reach to top rate if the difference between the 2 is larger than current bands.</p>

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	<p>This will lead to a number of people being left with inadequate support.</p> <p>5) It is fairer for claims to be based on the needs and circumstances of the individual applying. Someone might have a diagnosis of MS but have hardly any symptoms, whilst someone might have ME and be totally incapacitated and reliant on the support of others for everything. The medical label should not dictate the entitlement. On the other hand, for this to work, the system must allow for quick and responsive reviews of people's circumstances.</p> <p>6) Local authorities prioritise their funds on the most dependent disabled people, in critical and substantial need, concentrating on providing support for eating, personal care, getting in and out of bed, but rarely for actual independent living. It is extremely important that the new benefit provide support for people in substantial and critical need, as well as to people who are not in critical or substantial need but who are still incurring the additional costs of disability. Otherwise they might no longer be able to work or attend additional training/education nor live an active life including family life. This is crucial to anyone who needs support with mobility out of the home and for support with daily activities such as cleaning, laundry, shopping, meal preparation etc. DLA levels were never sufficient to cover all these areas fully but losing such entitlement, for people who receive no support from their local authority could lead to no longer being able to live independently nor to work.</p> <p>Activities which are essential for everyday life are: eating, drinking, preparing food and drinks, personal care, getting dressed and undressed, toileting, communicating with others, accessing information regardless of hearing or sight ability, learning, caring for others including children and/or adult dependents, caring for one's home, accessing one's local neighbourhood, accessing health facilities (primary care as well as hospital care); accessing culture, leisure and fitness facilities;</p> <p>8) Aids and adaptations do not get rid of someone's disability. They may render life slightly easier but they rarely lower the cost of disability. It is therefore not appropriate to take into account aids and adaptations in an assessment.</p> <p>9) In part, the form could ask openly what the person needs to purchase/spend money on, which they would not need to if they were not disabled, and to explain and quantify this. Two people with the same impairment will not have to incur the same expense, given they have different lives and different family circumstances etc. A disabled person who works for an employer who insists on formal dress at work might incur great expense on bespoke formal clothes and footwear whereas someone with a more extensive impairment, who does not rely on bespoke clothing (or who does not work, or whose employer does not insist on formal dress) might incur lower bills.</p> <p>Similarly, someone who has 3 children might incur higher transport bills (due to needing to get the children to school and not being able to walk to there, nor to their activities, their health appointments, etc) than someone with a higher level of impairment but no children/other dependents.</p>
ONLINE103	<p>1) There are many barriers, both in the physical environment and in other people's attitudes and lack of knowledge of disability, but one of the main obstacles is lack of access to suitable transport</p> <p>2) My main concern is that disabled people living in residential care homes should not be discriminated against in terms of financial help towards their transport needs. The personal expenses allowance of £22-30 per week for younger adults living in residential care homes is barely adequate for such necessities as toiletries, clothing, etc., and certainly does not provide the means to get out to any entertainment facilities, shops, etc. Funding authorities (local authorities, which are having to severely restrict expenditure) do not make any meaningful contribution towards individual transport expenses. So if the new Personal Independence Payments system does not include some financial help towards transport costs for people living in residential care homes, they will be condemned to a life that is little better than house arrest.</p> <p>2) My particular concern is that severely disabled people living in residential care homes should not be discriminated against in the provision of financial help with mobility. The weekly personal allowance of £22-30 per week for younger adults in residential care is barely adequate for basic needs such as toiletries and clothing, and certainly not for transport to enable them to access any entertainment, shops, day centres or any other social activities. Without some financial help towards mobility needs, they are in a situation little better than house arrest. Their lives are already restricted more than any other section of society as a result of their disability. There is no realistic prospect that their funding</p>

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	<p>authorities will make any contribution towards their individual mobility needs, so continuing financial provision for their transport expenses is essential to maintain something like a reasonable quality of life for them.</p> <p>6) I do not see any valid reason why people living in residential care homes should be discriminated against by not receiving financial help with their transport expenses. Their funding authorities (usually local authorities, which are now having to make severe cutbacks) do not make any meaningful contribution towards their mobility needs (the best that can be hoped for is that they may take into account a care home's costs in running a minibus - and they probably won't). Their need for financial assistance with transport needs, to give them something approaching a reasonable quality of life, is no less than that of people living in their own or other forms of accommodation.</p>
ONLINE104	<p>5) All claims should be based on the needs and circumstances of the individual applying. It would be ridiculous to say, for example, that everyone with arthritis should qualify. You may get someone who is classed as having severe arthritis from an x-ray who manages with very little help, and someone with mild to moderate arthritis who finds it debilitating. People perceive pain differently and cope differently with impairments. There is also the different medications to be considered. Some people cannot tolerate or cannot take certain medications. Therefore, each case should be assessed individually.</p> <p>10) A medical report from the hospital and/or GP would indicate what the customer's condition has been like over the years. A medical examination report, along the lines of the work capability assessment, would further clarify their abilities/needs. Both are valuable sources of information, and in conjunction help to reduce fraudulent claims, especially useful with customers who are convincing actors. This would then free up resources to help genuinely disabled people who need the help.</p>
ONLINE105	<p>10) cant see any of the first questions, perhaps you really dont wish to hear the questions.</p> <p>my issue is i have MS a condition that is very variable, i can be ok for a week then bad for week after. i use my mobility part of dla for my car, which allows me to attend university and hopfully get a job in the end, if i did not have my car i would be unable to work, i cannot afford to buy a automatic car so effectivly i would be unemployed. I want to know how i would get assessed for any changes, my gp who i have been with for 6 years admits he knows very little about MS would you be consulting with the specialist MS nurses to guide any assessment or just getting a general doctor who may not have an understanding of how the condition's affects individuals, or are you just going to do a computerised questionnaire where it will not ask the questions that relate to a condition that is variable</p>
ONLINE106	<p>5) I think you could safely award DLA automatically after a diagnosis of type 1 diabetes and then review after a couple of years to see how the person is responding to treatment. I am the parent of a child with diabetes.</p> <p>6) Please do not take away the mobility component for people in care homes! Some people need trips out of their care home to maintain an interest in life, for mental stimulation and learning, and they cannot access this if they also have mobility difficulties. (I speak as someone who has worked with families of disabled people.)</p> <p>11) I am the mother of a diabetic child. I would not like to discuss her needs in front of her. I do not think a face to face meeting with a health professional would serve any useful purpose in deciding entitlement to DLA. My husband and I are as positive as possible about diabetes when our child is within hearing. She knows there are many dangers, but we play these down and do not draw attention to the many things we do to keep her safe. The worst thing I have had to do in my life was fill out the DLA form because I had to admit to myself what we are facing. I could not let my daughter go through that. Statistically, she is at greater risk of depression because she has diabetes, so I put a huge amount of thought into supporting her good mental health as well as her physical health. Do not underestimate the emotional impact on young people of suddenly being diagnosed with a life-threatening condition</p>
ONLINE107	<p>1) Firstly, it depends on the nature of the disability. I write with reference to severe learning disability, challenging behaviour, medical needs, complex etc.</p> <p>People such as this are on the edge of society and not accepted, although we would like to believe they are. Accessing activities that others take for granted is very difficult. Usually requiring a lot of planning and support ( 2:1 support is not unusual) and transport.</p>

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	<p>Individuals with challenging behaviour can be unpredictable and hence not accepted by others. e.g. simple things like a trip to the cinema or a restaurant are often out of the question. Other activities need to be offered so that an individual (and the family) do not become further isolated from society/community. Services are only really kick in when there is a problem and then you are constantly reminded that the person you care for is expensive.</p> <p>2) This sounds pretty much the same as now, apart from mobility for those in care homes, so what's different? I can only conclude it must mean less money. Mobility allowance must remain with people in 'care homes'. I feel this issue is very much misunderstood by government. Most people when they hear care home usually think of an elderly infirm person seeing out the last few years or months of a long life and perhaps such people don't go out and about in the community. (E.g. we have an elderly relative that has lead a full life but at the age of 90 went into a care home). Nothing could be further from the truth when it comes to disabled people. Firstly, there are many different settings a disabled person may live: cared for by family, 'supported living', in both settings the disabled person continues to get mobility to access the community and get on with the necessary functions of daily life. However, some disabled people (particularly those with LD) live in settings that are defined as 'care homes', however, the type of life they lead is no different to the previous two. Care homes today often mean just a couple of people in a home with carers rather than the 'institutional settings of the past or old peoples' home. I must stress this is very different. Removal of mobility allowance from this group of people will restrict their lives (giving the money direct to the council will mean this money will not get to individuals?). They will be left to live on £21.00 per week and that is not a life. How is it possible to access the community or lead a 'normal' life? These individuals will not have freedom of movement. Normal activities will no longer be accessible. The result will be institutionalisation and thus, turning the clock back to 'locking' people away from the rest of society. It is so hard to get any support from Social Services and now to think that they will control this money rather than the individual is totally unacceptable. Yet, at the same time, those who continue to be cared for by family or in supported living will continue to receive mobility, how can this be right? Why are freedoms being removed from those in care homes? I can only conclude that people who are ignorant and totally out of touch with modern life for people with more complex needs and disabilities have made this recommendation. This aspect of DLA must be looked at again. Also, in terms of financial saving it is very small but the impact is devastating. This does not seem to be protecting the most needy and vulnerable. My adult son may eventually move into a care home and will have to live on £21.00 per week; he will not be able to do the things he does now and thus his life will be very limited. Social Services or other bodies will not give this money or freedom.</p> <p>3) I respond with reference to severe learning disability and challenging behaviour:</p> <ol style="list-style-type: none"> <li>1. Transport: this group do not access public transport; therefore, getting out and about requires a car/taxi. It may be challenging behaviour, mental health needs, and complex medical needs etc that make access to public transport impossible.</li> <li>2. Special diet related to the disability.</li> <li>3. Abnormal wear and tear on clothing etc/specially made clothing/shoes.</li> <li>3. Washing - incontinence means abnormal amounts of washing.</li> <li>4. Damage/wear and tear on the household items through challenging behaviour.</li> <li>5. Adaptations to the home environment to make it safe</li> <li>6. High number of appointments, medical or otherwise with someone to transport and support.</li> <li>7. Support in the home: care, cleaning, management of daily life- shopping, bills etc</li> <li>8. Someone to be available 24/7 to meet all needs.</li> <li>9. Extra cost of every day requirements that have to be carried out by a special/specialist person due to the person's challenging behaviour e.g. having a haircut is not straight forward.</li> <li>10. holidays require specially adapted accommodation and often requiring safety aspects not necessary for a non disabled person but this all comes with a far greater cost plus 24/7 care.</li> <li>11. If a carer accompanies the disabled person in the community then the disabled person has to pay for the carer at the activity also, thus it is double the cost for a disabled person to go bowling or out to the pub because he/she pays for the care worker.</li> </ol>

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ONLINE108	<p>1) The barriers are many. they can be described by 3 categories:  Access barriers - eg acces to the written word or the physical environment  Attitudinal barriers: eg treating disabled people as children, as lesser beings, as burdens on society or economically unproductive or as dangerous - amongst others  Assistance barriers: eg some disabled people need 1:1 assistance - often because the barriers are not addressed (eg blind people may need readers because not all information is in appropriate formats)  All of this is underpinned by the social model of disability. unfortunately, far too many organisations which purport to assist disabled people, including the government, still revert back to a medical model of disability. This in itself is a barrier - eg the over-involvement of health professionals in assessing benefits rather than relying on disabled people's own experience of the barriers we face.</p> <p>2) Entitlement for life: this gives disabled people security and allows people to plan ahead for the future - eg through use of the motability car scheme  Automatic passporting: though I agree that this is a medical model approach rather than looking at individual barriers - this has a social model outcome in terms of enabling people to remove barriers. If one of the goals of the project is to simplify DLA for disabled people - automatic passporting is one of the easiest ways to achieve simplicity becasue it takes away subjective responses from individual medical professionals/ DWP assessors where disabled people facing the same or very similar barriers end up on different rates of benefits - leading to a lottery dependent on the individual assessors.  Disabled people living in care homes should keep their entitelement to the mobility component as they are not living in hospitals - they are living long term in their home. the government shows, by removing this, a fundamental misunderstanding of the purpose of residential care as part of the social care system. People living in care homes are among the most oppressed disabled people in society - how can the government say it is targetting benefit at those who need it most and wanting disabled people to maintain independent lives, then taking away the only bit of independence many people living in care homes have? Firstly, the care homes don't get this money from councils. secondly, and more importantly, even if the care homes did get the money this method takes the money away from individual disabled people so taking away their independence and autonomy.</p> <p>3) Do not make the mistake of lumping all disabled people together. we are individuals, therefore face differing barriers and differing costs to assist the removal of these barriers. Access barriers; costs include accessible transport, the additional costs of materials in accessible formats, equipment, clothing, additional heating (because people are at home due to other access barriers), higher food costs (eg if people need easy to prepare food), communication costs (eg increased phone bills to stay in contact with people, internet etc)  Attitude barriers; because disabled people are disadvantageded in education and the job market, this means we are less likely to have access to other income and more likely to rely on benefits.  Assistance barriers - costs of employing personal assistants, sign language interpreters etc, also people have to pay people to carry out tasks in the home and garden eg maintenancwe, decorating, gardening that non-disabled people may do themselves. Some commercial services can provide assistance to disabled people but come at a cost eg ordering your food shopping online.  The list is endless.</p> <p>4) At the moment, 2 rates of mobility and 3 rates of care is not particularly complicated. Sometimes change in itself is a complicating factor - as everyone receiving care component will have to be reassessed to move from 3 levels to 2 levels.  It is impossible to comment precisely on the potential disadvantage until the rates of the new benefit are known and can be compared with current DLA. However, bearing in mind the government's stated aim to reduce the cost of DLA, this can only mean that there will be many losers - including more people currently on middle rate moving to lower rate. Disabled people, as ever, will be disadvantageded.</p> <p>5) I think automatic passporting should stay.  Automatic passporting: though I agree that this is a medical model approach rather than looking at individual barriers - this has a social model outcome in terms of enabling people to remove barriers. If one of the goals of the project is to simplify DLA for disabled people - automatic passporting is one of the easiest ways to achieve simplicity because it takes away subjective responses from individual medical professionals/ DWP assessors where</p>

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	<p>disabled people facing the same or very similar barriers end up on different rates of benefits - leading to a lottery dependent on the individual assessors.</p> <p>There is an increased admin cost in removing automatic passporting - and this is likely to be taken from the overall budget for this benefit - another way that these proposals disadvantage disabled people.</p> <p>6) This is a trick question. the whole aim of personisation is that disabled people ourselves can chose what is important to us as individuals. For example, one person, given 4 hours personal assistance would want the personal assistant to clean their house as a top priority, another person may want to go out and see friends, another person may want to go and see a welfare benefits officer.</p> <p>All activities that non-disabled people choose to do to maintain their wellbeing and lifestyle are important to them - the same goes for disabled people.</p> <p>This benefit should not be judging on the importance of different activities (social care eligibility criteria have gone down this route and have never got it right)- the benefit should be allowing individual disabled people to define the barriers they face and therefore what they spend the money to - to maintain our basic human rights.</p> <p>7) Ask the disabled person. Ensure the disabled person has an opportunity to say how barriers affect their lives when their condition is most affecting them or when they are struggling to carry out tasks, when the condition is affecting them in a lesser way. Remember that having a fluctuating condition does not mean that you can necessarily change your support arrangements quickly and you cannot tell when your condition is most likely to affect you. The DWP cannot keep reassessing people if their conditions change. The uncertainty of whether you are going to lose benefit can also add stress which can exercerbate people's conditions, for example mental health conditions.</p> <p>8) This is deeply offensive and shows total lack of any understanding. How do you assess how someone can get about in their wheelchair? can people only go to accessible places? Will you take account of people wanting to go to places where there may be slopes/steps/ rough surfaces/ roadworks/crowds/ temporary obstructions/bad weather etc which may mean that a wheelchair user needs to use an additional method of transport or assistance? Where do you stop? If a blind person changes their white cane for an updated model, will they have to be reassessed? if someone has a grab rail fitted, will their benefit for daily living be reassessed? It seems odd that people using prosthetic limbs have these taken into account.</p> <p>This is also counter-productive as many people use DLA to buy the aids and adaptations that you are talking about. People may actually decide not to buy, for example a mobility scooter, for fear that buying the best thing that will help them to achieve independence will remove their benefits.</p> <p>Its just yet another way of removing DLA, using some strange logic invented by non-disabled people who have no understanding of disabled people's lives and the struggles we face. I thought you were trying to make DLA simpler - this makes it very complicated indeed.</p> <p>9) 1. Reduce the need for intrusive assessments by medical professionals and have the disabled person's views at the centre of the assessment - not increase medical assessments</p> <p>2. I think the government has overstated the current difficulties with the system. The forms could be made simpler with more guidance. The government could advertise the benefit using popular media - eg TV and radio.</p> <p>3. Altering the benefit process and entitlement are the two things that is going to make the process less postive and more complicated</p> <p>10) The disabled person is the best person to ask about their own circumstances. Health professionals are not the best people to make decisions - as disabled people are the experts in the barriers we face and the lives we live. Very few health professionals work from the basis of the social model of disability - therefore they cannot make the right judgements about DLA</p> <p>11) Benefits - none Difficulties - many</p> <p>Very few health professionals work from the basis of the social model of disability - therefore they cannot make the right judgements about DLA</p> <p>Having health-related assessments is very stressful for disabled people</p> <p>Health-based assessments are counterproductibve when using a social model approach</p> <p>This will be an expensive exercise and is likely to take money out of this budget - taking</p>

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	<p>money from disabled people to fill the pockets of medical professionals and the private sector. You are turning DLA into an industry benefitting officials and medical staff rather than a simple system to compensate disabled people for being disadvantaged by society</p> <p>12) The current system works fine - with many disabled people receiving DLA for life when it is clear that their impairment will not change in a way which means they would not need DLA.</p> <p>Putting in reviews stops disabled people from planning ahead - eg from using the motability scheme - for fear that they may lose their benefit, and therefore their vehicle and, ultimately their independence.</p> <p>13) Very few DLA recipients have conditions that improve. many more people are likely to have conditions which deteriorate. Therefore, there is probably more underpayment of DLA than overpayment. The government is focussing on the wrong issues.</p> <p>If someone has a condition which may improve, then the DWP does not award DLA for life so people have to reapply after a period - this should address this issue.</p> <p>?) Advice and information should be offered but should not be compulsory. This advice should be provided through peer support by disabled people's organisations - in line with previous govt policy having a CIL in each local area. This must be confidential advice and support and definitely not linked back to whether the person is entitled to DLA.</p> <p>It is important that the government do not think aids and adaptations are a quick fix that will reduce the DLA budget. Most disabled people, even with all the aids and adaptations available still face barriers to equality. This is because disabled people have the right to interact with the rest of society - not sit in a technical bubble at home. For some disabled people, eg people with learning difficulties or mental health service users, the barriers are not removed by having technical equipment at home. For other disabled people, levels of pain, tiredness, anxiety etc can have a big impact on whether people can use technical aids or may need assistance from a human being to do the same task - or just be able to go where they want to</p> <p>?) Howe long is a piece of string? people fund aids and adaptations through lots of ways - saving up bit by bit (either DLA or other money), through disabled facilities grants, though loans of equipment from councils/NHS etc</p> <p>If PIP is going to meet a one-off cost, this should not be an 'either /or' situation - this should be in addition to funding for ongoing costs such as personal assistance.</p> <p>Equipment alone does not give people choice, control and independence - see previous answer</p> <p>?) I believe this will have a disproportionate impact on some equality groups. For example lesbian, gay and bisexual people (LGB) may need to travel more to keep up contacts with the LGB community/friends, rather than heterosexual people who are more likely to be able to socialise with people on a neighbourhood level, rather than a city/area level. This means that lesbian, gay and bisexual disabled people tend to have higher transport costs than heterosexual disabled people. See, for example the Rainbow ripples report at <a href="http://www.rainbowripples.org.uk">www.rainbowripples.org.uk</a>. Also, traditional forms of non-assessed social care support may not be suitable for lesbian, gay and bisexual disabled people due to homophobia from those services or others using the service, such as voluntary sector run activities or peer support for disabled people. Therefore some LGB disabled people wish to use their DLAs to buy in appropriate support - such as a personal assistant from the LGB community to assist them to access culturally appropriate support for LGB people. there is also some evidence that lesbian, gay and bisexual older people are less likely to have informal support from their biological family or neighbours- partly due to the fact that LGB people are less likely to have children, but also because LGB people may have been disowned by their family, or may not have come out to family or neighbours, so it is difficult to receive appropriate support. Many LGB people are isolated - and DLA can be used to mitigate this through having choice and control over transport and contact with dispersed community and friends.</p> <p>Some Black and minority people may face similar issues around using DLA to buy in culturally appropriate services and enable travel if their community is also dispersed wider than the immediate neighbourhood e.g. if the person is living in a different part of the city to the main activities of their cultural community.</p> <p>The Equality Impact Assessment has failed, in that it has only looked at quantitative monitoring rather than the significant amount of qualitative information now available about the specific issues for disabled people from minority communities.</p> <p>?) Passporting to other benefits may be complex - but so are the additional costs that</p>

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	<p>disabled people face. If there is no allowance in the PIP assessment for additional costs that are currently covered for non-disabled people by other benefits - eg heating costs or laundry costs which are covered by IS/JSA or the proposed Universal Credit, then universal credit should be higher for disabled people - otherwise disabled people are not having all the additional costs recognised.</p> <p>The Motability Scheme will only continue to work if disabled people are confident that their award of DLA/PIP is going to be for long enough. Otherwise, disabled people will not want to use DLA/PIP for a lease car, for fear that their accessible transport will be removed suddenly from them, on the basis of reassessment. This is just one example of why the government's proposed reforms of DLA are so flawed.</p> <p>?) The principles should be the same - that DLA or PIP should assist the person (or child's parents) to remove the barriers that prevent the person gaining equality with non-disabled people - so for disabled children, entitlement to PIP should be based on enabling the child to do equivalent activities that are available to non-disabled children of the same age.</p> <p>?) There is a balance to be struck between the fact that we, as disabled people, have to repeat the same information many times to different people (and the administrative costs of this to the state) and disabled people being in control of our own information. Passporting that enables the disabled person to use the information that they are entitled to DLA/PIP seems like a good idea.</p> <p>However, if DLA is going to be removed from more people and is going to be a less secure benefit with more frequent reassessments, making DLA/PIP the passport for many different benefits (cash or kind) could increasingly divide disabled people into 2 groups - the 'haves' and the 'have nots' on the basis of DLA entitlement. This could massively add to the stress for disabled people facing reassessment. It should depend on equivalence - for example a local council may want to offer reduced prices for their leisure centres to a wide range of people who may benefit - the entitlement for DLA may be too narrow to achieve this, or it may be set at an OK level. So it is hard to make generalisations about whether using DLA as a 'passport' is a good idea.</p> <p>?) There is a balance to be struck between the fact that we, as disabled people, have to repeat the same information many times to different people (and the administrative costs of this to the state) and disabled people being in control of our own information. Sharing information about us without consent is a breach of our human right to privacy.</p> <p>Information should only be shared with the disabled person's consent and it should always be possible for the disabled person to decline to give consent for information sharing without this meaning that they are unable to receive another benefit/service. ie if the have been assessed for benefit/service X but do not want the staff involved in this assessment to give the information to service Y, the disabled person should always be able to approach service Y directly to start their assessment process. This provides an important safeguard against poor or unfair assessment by one service having a massive knock-on effect across a number of areas of the person's life.</p> <p>?) There should be no requirements to take advice and support. Most disabled people would welcome more advice and support - they just do not happen to get much at the moment. There are long waiting to get assessments for equipment. Tightening eligibility criteria for social care mean that less disabled people approach social services for advice and support.</p> <p>The question is a strange one - it implies that disabled people, if they took advice and acted on it - would somehow qualify for less DLA. This seems to make little sense unless all aids and adaptations are taken into account (see q8) which is a premise that I do not support, for reasons given above.</p> <p>?) Why have you not asked consultation questions on some of the most controversial sections of the proposals/ especially, why is there no consultation question about removing the mobility component of DLA from disabled people who live in care homes? The point that has always been made by the coalition government is that people who live in care homes should be treated the same as people who are having a stay in a hospital. the facts that are omitted are that disabled people LIVING in care homes are LIVING in their own home and should be treated as individual recipients of DLA. People who are in hospital are often there for a short period. Saying that the care home providers are given money from local authorities is disingenuous on 2 counts</p> <p>a) it doesn't happen b) it takes the control away from the individual disabled person, as they then have to ask</p>

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	<p>the care home staff whether they can travel -which may be inconvenient to the care staff, there may be no transport provided and the disabled person does not have autonomy about where they are going or who they are going with. What is likely to happen is 'group outings' rather than individual needs being met - which compounds the institutionalisation of disabled people and could be challenged using the Human rights act in terms of freedom of assembly and association.</p> <p>These proposed measures are draconian and will be a setback for disabled people that will take us back to poverty levels of many decades ago. Disabled people are impoverished as it is and are likely to be amongst some of the poorest people in Britain - compounded by isolation and discrimination.</p> <p>None of these measures could possibly make life better for disabled people - or for society at large. We will be pushed back indoors. Out of sight, out of mind.</p>
ONLINE109	<p>1) Disabled people are still the most disadvantaged in the UK and still face near insurmountable barriers to participating fully in society. Despite equality laws and a better perception of disabled people we still face many barriers to independent living. Attitudinally we know that sometimes people don't listen to disabled people and there are still negative assumptions about what disabled contribute. Equality laws have not completely worked where disabled people for example still don't have access to higher education and training. We still feel injustice, and this consultation also makes negative assumptions and we find yet another threat to the support we need to take away the barriers we experience. The bureaucracy disabled people meet in trying to access means tested social care, some disabled people report that social services and employers don't believe that people's impairments are real ie ME and mental health conditions. Also stigma faced by disabled people - disabled people are still not treated equally in relation to support. For me personally physical access still remains a problem public transport has improved but I am still faced with extra costs for getting around.</p> <p>I still face much discrimination for example I couldn't go to a friend's wedding because of access. There are negative barriers when applying for jobs €□, there is ill treatment on public transport whether travelling by air, sea or land physical access and curt behaviour means travelling presents different barriers during each journey.</p> <p>Waiting times for equipment and adaptations is murderous and disabled people are missing out on opportunities because of this. ie when someone needs a wheelchair to get to work they need it immediately following assessment - not 3 months following assessment.</p> <p>Transport costs will always be significantly higher and this consultation cannot assume that just because disabled people have adequate equipment additional costs are not still there eg many wheelchair users cannot use their chairs in the winter because of rain or snow and still require accessible taxis to make even the shortest of local journeys.</p> <p>In my case some buses and trains become accessible with low rising buses and assistance on and off trains with station staff €“ I still need a support worker to accompany me where I need help being pushed up the ramp to board the bus. Assumptions are made that wheelchair users are all the same and if there is a ramp they will push themselves up the ramp €“ because of gradients and other barriers this is not possible.</p> <p>2) DLA or Personal Independence Payment must remain an extra-costs benefit, providing cash support and allowing disabled people to spend the benefit in the way which best meets their individual needs.</p> <p>Any new benefit to remaining non means-testing and should not be taxable, and not dependent on having paid National Insurance contributions. It is vital it continues to be available to those who are in work, as well as those who are out of work.</p> <p>Support will continue to be provided to children and adults up to the age of 65.</p> <p>Individuals who receive the benefit before reaching 65 may continue to receive Personal Independence Payment if their needs continue. This has to continue for the mobility component for those in residential care. Why would the Government think disabled people over the age of 65 have no need for help with transport costs to negate the barriers they face is beyond belief. Social care packages for those assessed as needing residential care does not include accounting for people's social needs. It is essential older disabled people get the chance to take part in activities away from their residential care.</p> <p>The mobility component is just as essential for disabled children and those under the age of 65 who use residential care.</p> <p>Keep special rules for people who are terminally ill with claims submitted under these rules fast tracked to provide financial support as quickly as possible.</p>

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	<p>Being able to go out on social occasions independently.  Making drinks and hot meals independently.  Why though €“ if the current DLA application process takes these questions into account would there need to be a different assessment process to judge whether disabled people need additional support to break down barriers?  Availability of financial support to negate physical and attitudinal barriers. DLA only helps negate the barriers it doesn't remove them completely.</p> <p>3) Instead of mobility, what about 'getting around' €□? However, I don't believe there is thinking that the use of the word 'mobility' has a detrimental impact on the distribution of DLA. Of course the term mobility has wider meaning than just referring to people who don't walk, it has wider connotations about getting around the built environment and the barriers faced by those with walking impairments and those with mental health impairments where both these client groups need extra costs to negate the barriers they face in trying to get around. These client groups will use their DLA payments to offset the different barriers they face ie one group will experience more physical barriers while the other may meet with really difficult attitudinal barriers or perhaps other problems with access to information or help.  So 'getting around' including physical barriers and attitudinal barriers are some of the main extra costs:  Using public transport independently.  And 'Living Independently' additional costs are met in every aspect.  Buying equipment and adaptations.  Making adaptations to one's home.  Being safe in all areas of independent living.  Being able to go to the toilet or bathing independently.  Being able to go out on social occasions independently.  Making drinks and hot meals independently.  Why though €“ if the current DLA application process takes these questions into account would there need to be a different assessment process to judge whether disabled people need additional support to break down barriers?  Availability of financial support to negate physical and attitudinal barriers. DLA only helps negate the barriers it doesn't remove them completely.</p> <p>4) It may make it easier to understand but it won't necessarily ensure appropriate levels of support.  Having only two levels for each component will be dangerous for those on the cusp and make it very difficult to assess someone appropriately. By having only two components how can it possibly reflect the range of individual needs. It will make it impossible to reflect the many different needs and range of barriers having to be met. It would be particularly hard to assess those with needs that change from day to day.  If you only have two levels then the default for someone who is assessed as just missing out on the higher rate then the higher rate should be awarded.</p> <p>5) Some health conditions or impairments should mean an automatic entitlement to the benefit. That is because the nature of the impairments or conditions will readily indicate a need to break down barriers through the DLA award. It would also mean an unnecessary waste of money on assessing people who have been assessed and have medical consultants and GP's involved in the diagnosis of an individual's specific condition, health status or impairment.  The needs and circumstances of all disabled people must be met. It is very difficult to make up some kind of league table to reflect some disabled people having more needs than others.  On the face of it, for example, a wheelchair user may look to be more disadvantaged than someone perceived to have a walking impairment, but that is not so because both types of impairment would still have barriers using transport or breaking down barriers to employment.  Another example may be that someone with a mental health impairment would need someone to support them to use transport or go to the shops - they may need support to do this. Much in the same way someone with learning difficulties may need to take part in a meeting in the community or to volunteer to help a local voluntary sector group.</p> <p>6) DLA remains an integral part to all disabled people breaking down barriers to their full participation in society:  Getting out the home</p>

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	<p>Working and volunteering  Doing social activities  Using transport  Going to the shops Taking part in sport and othe leisure activities  Being with family and friends  Making food when one wants it  Sleeping and getting up when one wants to  Buing equipment when you need it  Help with making daptations  Help with buying adaptaations  Help with buying equipment  Having relationships  Looking after children and family</p> <p>7) My response has already laid out reasons why their does not need to be a new assessment given that disabled people have already been assessed by medical professionals in relation to their impairments. Their diagnosis should already confirm the need to break down barriers with the financial support needed to take away society's barriers to full participation.</p> <p>8) Again - repeating myself - no assessment.  No it should not.  I have already given adequate reasoning behind the likes of wheelchair users having equipment but that does not necessarily ensure certain barriers - like getting on a bus - have been taken away.  Or that someone has a upport worker to help them with things during part of the day only to e left without the support to do other thingsoutwith their assessment of need or what is included in their care package.</p> <p>9) Individuals contact their GP or health representative and they submit a simple response stating their patient or clients' impairment.  No need for a further assessment.</p> <p>10) GP or Consultant from a hospital department or agency dealing with a particular claimant.  But rather than call this supporting evidence why does this initial and diagnosis provided by appropriate personnel not show the waste of money involved in setting up a further assessment process.</p> <p>11) Again - face to face meetings have already taken place with healthcare professionals in realtion to a claimants impairment or condition. These people are known to the individuals and so only healthcare professionals known to the client have to deal with them.</p> <p>12) Again - face to face meetings have already taken place with healthcare professionals carrying out regular reviews in realtion to a claimants impairment or condition. These people are known to the individuals and so only healthcare professionals known to the client have to deal with them.</p> <p>13) To keep it simple let disabled people use their care professionals they know to submit a claim on their behalf and the claim form asks those professionals what level of support is needed from the outset. Simple. Send a letter every year to claimants letting them know that their health care professionals are asked to submit a form detailing any changes in a claimants' needs. During the intial claim a form may ask a health agent how often it would be appropriate to ask about an individuals' changes. For those with genetic conditions - well unless there is an unexpected avalanche of miracle cures for 200,000 different kinds of conditions - let it be - give all disabled people the finnces to break down the barriers they face.</p> <p>?) Disabled people currently have to save up for a long time, use credit caard hey cannot afford, get loans from banks and/or friends and family. Disabled people should - of course be able to use DLA to contribute towards aids and adaptations but a more effective means of statutory support would be to make one off payments in addition to the DLA payments disabled peopl receive. A one off payment made by DH/DWP to meet the costs of one off items of equipment ie like when someone needs a ramp for their house or equipment relating to telecare or a computer to adminster a direct payment.</p> <p>?) Make sure consideration is given to the specific barriers faced by other equality groups eg protecting those who don't speak english as a first language .</p> <p>?) Many people need access to independent advocacy and this should be readily available through advocacy agencies in the claimants locality, ideally made by local centres for</p>

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	<p>independent living as called for through the Putting People First concordat.</p> <p>?) Never mind assessments - there is ongoing dialogue with GPs and consultants - there must be a way of using the professional diagnosis/evidence of condition/illness and impairment during the application process to take away for the ridiculous pointlessness of another assessment of an individuals condition or impairment - and it is never going to be anything more than medical.</p> <p>?) The Government should remove the upper age limit for receiving the new benefit. It is an injustice for the Government to think older people who become disabled after the age of 65 have no need to receive the financial support offered by the DLA mobility component to break down the barriers that are met by disabled people under the age of 65. Older disabled people over the age of 65 still have the same barriers to getting around. Ain't no point in having a bus pass unless you can get to the bus stop or get on the bus to use it.</p> <p>?) Yes - a requirement by the Governemtn to fund the level of advocacy for disabled people that is needed. A suitable level of advertising and marketing to ensure that those who need to access advice and support, where appropriate, can get the help they need to encourage the thousands of people who don't reeive the support they are entitled to. The Government must avoid inapproapriate means of communication that does not support disabled people in the process of making a claim and submitting updates about possible changes i circumstances.</p> <p>?) Yet more barriers to participation would be the result.</p>
ONLINE110	<p>1) Flexible working conditions, aids to assist in getting around, being given extra time to complete tasks. I suffer with fibromyalgia and I have mobility problems, cognitive problems, and am in constant pain. I have spent a long time trying to think of a job that I can do. Ideally, I would like to be able to find a job where I could work from home.</p> <p>3) prescription costs, payment for home support and help, transport for those unable to stand at bus-stops, or unable to drive themselves, or unable to enlist the help of family and friends to take them to appointments- many disabled people become housebound which leads to increased mobility problems and depression. Heating costs, being able to maintain a comfortable living environment. Cost of living aids and adaptations made to the home.</p> <p>5) I believe that claims should be based on the needs and the circumstances of the individual applying with an assessment from an independent doctor, combined with medical reports from GPs and hospitals also being taken into consideration. Too many people are claiming benefits for alleged health conditions (they have the knowledge to play the system) whilst honest people who require genuine assistance are unable to claim extra help because they do not know how or where to get help from.</p> <p>6) Being able to visit family and friends, being able to concentrate and communicate with others, being able to partake in some form of fitness activity where able. having someone to talk to, and help with household tasks and shopping. advice and support for maintaining health- diet and exercise. Feeling that your life is worthwhile.</p> <p>7) Regular and detailed assessment of needs. Spot checks!</p> <p>8) Whilst using aids can help a person to get around, many people experience extreme pain and it is this that prevents mobility. I have rails fitted and aids to assist me in the home, and whilst they enable me to get around safely, extreme pain still prevents me from doing many things.</p> <p>10) Independent healthcare professionals combined with GP and hospital reports.</p> <p>11) Face to face meetings are essential- assessments would be better if carried out in individuals own home for those less mobile, allowing for a better assessment of mobility issues. Carers should be present.</p> <p>14) Help in completing forms - many people who have to claim benefits have never claimed anything before, and currently it is difficult to know what you are entitled to. SWAN advice network were a godsend but have had to close due to lack of funding. CAB were useless and provided no help whatsoever. I was able to have rails fitted and aids supplied after just one meeting with SWAN, whereas I had been seeing different people at the CAB for months and was provided with no information or advice with regards to help with mobility aids and support.</p> <p>15) I was told about how to apply by SWAN advice network- although I had previously been to the CAB, my GP, and the rheumatology hospital on many occassions and no-one told me how I could get advice, help and support.</p> <p>16) I paid for many of my own aids, as benefits have been slow to come. After more than a year I am still trying to get some help with mobility and I am waiting for a tribunal date, after being refused help.</p>

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	<p>17) Emotional issues- the provision of regular support and counselling to help a child manage the emotional impact that their condition has had on their daily life and relationships with friends and family.</p>
<p>ONLINE111</p>	<p>1) If there is a reduction in the mobility component it will seriously affect the ability of those affected to lead a full and normal life and impinge on their Human Rights giving them fewer opportunities in life and therefore affecting equal opportunities. These assessments are seen by many as a cost cutting exercise directed at the disabled and many disabled are likely to be distressed and under stress as a result. A reassurance that those receiving means tested benefits will not lose their cars or the money to pay for them would ease their concerns.</p> <p>1) It's actually been very good. Perhaps a little more electronic notification between depts instead of having to send the original in as proof could be arranged in this day and age.</p> <p>1) Lack of flexibility by employers and society ie working hours, sick days, parts of the day when you're not able to participate etc.</p> <p>Also I have a small business as a self employed journalist. It causes so many extra forms and letters to inform the various Depts. Is this really necessary?</p> <p>2) Motability Scheme would be a problem. Also council care and benefits systems would be a problem. There are more but I just can't think right now.</p> <p>2) The Motability Scheme should stay the same for those on means tested benefits as people rely on it to lead a normal life and work.</p> <p>Anyone on means tested disability benefits should have DLA reductions made up so that they can retain use of the scheme. If they are prevented from working and a normal life they will become desperate.</p> <p>3) DLA and Incapacity Benefit and Local Authority Social Care as above, but if a mistake is made it would be devastating</p> <p>3) Extra mobility like car when others can walk, hiring a mobility scooter at events, personal care, heating, washing, special diet, paying for jobs to be done when others can do these things themselves, house and mobile telephones are essential for safety so a lifeline can be installed where just a mobile would do etc etc.</p> <p>4) Anyone needing Personal Care with showering, shopping, getting a walker out of the car, and preparing meals etc currently on the middle rate will lose money but at the same time have to pay more for the care as the council are putting up their charges. If two levels are proposed then the higher charges levied by local councils will need to be taken into account.</p> <p>5) I agree that all claims should be based on the needs and circumstances of the individual applying. However, I feel that there will be cases when a second opinion could be required, and this could be expensive and time consuming, but in the interests of justice should be available.</p> <p>6) Managing Personal Care and Treatment needs and accessing food, drink and adequate heating are essential if the minimum we all require just to function and are therefore the most essential for everyday life. The social care assessments are currently made by non medical staff, and if medical staff did them I wonder if the problem would be resolved. The carers are a real help to their clients giving some welcome social interaction as well as helping with Personal Care.</p> <p>7) Variable and fluctuating conditions can be just as devastating as others and can cause someone to lose their job because the inability to work several days in a row, or several hours at a time. Others going from flare up to remission often find that their symptoms are caused or aggravated by a return to work. Therefore the best way to assess these conditions is by asking what can be done and then what effect doing this has in the short term and in the long term.</p> <p>8) The assessment should consider any aids and adaptations that the person is definitely eligible for and there are definitely stocks of provided that there is no reason why there is no likelihood of an adverse reaction or suitability issue.</p> <p>9) All government benefits must work on a tick box system which are kept very secret to avoid the clients knowing what the right or wrong answers are. Supposing the form consisted of the tick boxes and it was just a matter of verification on a percentage which can easily be done these days. Personalisation could be achieved by asking the client to describe how they go about doing something.</p> <p>10) GP in first instance as they have a good overview of the complexities, the consultants who deal with the details, and the social worker/support worker. In many cases the support worker sees the client and knows the client more than the social worker does.</p>

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	<p>11) Issues re race and religion need to be considered.</p> <p>12) Reviews are always likely to be stressful for the client, so should be kept to a minimum. Evidence could be taken from the consultants or GPs at regular intervals as regular checks and visits would be made anyway.</p> <p>13) Can I suggest that a declaration that nothing has changed should be sent and returned with a signature on a regular basis?</p> <p>14) Can I suggest what I do. I lease a Motability car and use it for myself, but also help my Mum with it taking her where she needs to go. If people could help others in this way, and there was a database at a local level helping people to get together, maybe fewer people would be needing Motability cars or assistants.</p> <p>15) I feel that any requirement has that element of compulsion and is to be avoided. Could this situation be helped by encouragement from their GP's?</p> <p>16) From independent retailers. This is an expensive area and would be greatly enhanced by a one off cost option.</p> <p>eg Problem- Someone who has a Motability Car and therefore using whole allowance cannot therefore have a mobility scooter. If they had the scooter they could get to shops alone provided that they could get it in and out of the car. In fact they could do so much. I have a 4 wheeled walker which is now rather battered and can't get replacement parts so I need a new one and same with my wheelchair which I use for longer distances. It would fix these problems.</p> <p>17) I'm afraid I don't know</p>
ONLINE112	<p>1) Primarily mobility</p> <p>2) Those who have DLA before 65 should be able to continue to receive PIP after that age. They should be able to choose how to spend PIP.</p> <p>3) Heating, diet, wear and tear on clothing and transport.</p> <p>4) I don't see how two rates of benefit for each of two components will simplify the overall structure or make the benefit easier to understand.</p> <p>6) Both elements of this question are very difficult to answer. Surely people without a disability have all the essential skills necessary to undertake everyday life whereas those with a disability do not? The difference between the two indicates the level of support required. The extent to which it can be provided depends on money.</p> <p>7) Reviews at intervals decided at the initial examination.</p> <p>8) Everything that is available but there must be a financial limit, whoever is to pay. Because the NHS calipers were so poor I bought my own out of a small inheritance. I was lucky to be able to do so.</p>
ONLINE113	<p>1) This is a complex question. At one level there is a lack of accessibility to all sorts of buildings and venues (in spite of legislation). Then there is the issue of parking spaces for disabled people €“ and their regular abuse €” and unsuitable meter machines located up inaccessible kerbs and car-park barriers that are hard to use if, e.g., you have arthritic arms and fingers.</p> <p>Or it can be at a personal level: homes of relatives are not always disabled friendly and are not equipped with stair lifts, beds at the correct height, grab rails in toilets, walk-in showers, etc.</p> <p>There is a wider issue that some disabled facilities do not meet the needs of all. A further barrier appears to be the lack of willingness of the government to continue to fund DLA and Incapacity Benefit (IB) where appropriate.</p> <p>2) Pretty much everything except the complexity of the form.</p>
ONLINE114	<p>1) A fundamental change of attitude of both society government, particularly central government. Like all groups who are in the social security system, the disabled are considered to be potential featherbedded scroungers. Unfortunately our society has a long history of intolerance towards the poor and those who are in someway different, so there is little or no room for individuals who access the social system.</p> <p>Current societal definitions of value are monetary and the Victorian concept of the deserving poor. These are being translated into government policy to the extent that we now have the Victorian concept of the deserving poor almost driving social policy and 'benefit' cuts.</p> <p>What the disabled require is compassion translated into action so that all disabled are not to live in fear the State taking away from them any financial assistance that they may receive or that they are labelled as scroungers and potential benefit cheats. Society has a duty to care for those who are unable or find it difficult to care for themselves.</p>

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	<p>5) Some conditions need to be automatic. Indeed the list should be lengthened and strengthened. For example. At present only double amputees get automatic entitlement. However, what about the individual who is not a double amputee but will never be able to use their legs again? Again, what about the individual who has had a leg amputation? Their problems are nearly as great as those who are unable to walk at all. I would argue that the starting point should be that there are conditions that should attract automatic entitlements and then levels be determined. However, care and compassion HAVE be the key words when assessment takes place, not cold objectivity.</p> <p>6) If you were to list all the activities that are essential for everyday life. Depending on your point of view, you would have either a blank sheet of paper or a list so long it would take a lifetime to read.</p> <p>8) Aids have a limited use and in themselves can cause problems. I would not take aids and adaptations into account. You could take into account the use of prosthetic limbs. In doing so, however, you would also have to take into account the amount of pain the user has to bear when using it. What about the use of crutches, the individual is unable to do many functions. Try going shopping and then carrying the bags. Finally, some people have a board to help them get into and out of a bath. Take my word for it, the acts of getting into and out of a bath is still difficult and border on dangerous.</p> <p>9) Do not be prescriptive!!!! All you need to know is, the nature of the condition, how it affects the individual, medications and how long the condition is liable to last. Information can be verified by approaching the relevant medical specialists and/or interview with a qualified medical practitioner. Allow the individual to be descriptive. This of course flies in the face of objectivity, but social science research uses description as a valid method of data collection. Be honest!!!! For a start publish the criteria before starting the process, thus allowing individuals to see what they are in for. Canvass widely the form and criteria to be used.</p> <p>10) You have to define what the term ability means. Ability to do what exactly. This is the main problem with exercise. No one has said what the whole exercise is about. There are lots of soothing phrases but as yet no definition as to what disability really means.</p> <p>12) If you are amputee, no grow bag in the world will help the missing limb regrow. The nature of the disability would in most cases make it self evident whether or not constant reviews are necessary. Referring to the claimants medical professional would be the most useful.</p> <p>?) It will effectively marginalise large numbers of our society because they will fall outside the criteria and would therefore be impoverished both financially and socially.</p> <p>?) Complete access to the criteria and copies of the form used in the assessment process.</p> <p>?) Despite the rhetoric, one cannot help but feel that this consultation will achieve its aim as a cost cutting exercise. There is not one disabled person in the land who wants to be in the position that they endure. We would all like to be physically and mentally fit. Unfortunately, this is not the case. What makes it all worse is the fact that central government and society as a whole consider us as potential benefit cheats, a nuisance and/or embarrassment. What sets a society apart is its treatment of the poor and the sick. Our record is poor. Is it fair that in order to save money many must be cut adrift. Your government talks about fairness. On this issue, your actions must prove that all the talk about fairness is not simply rhetoric.</p>
ONLINE115	<p>1) Part of it can be just stigma. If you have a mental health disability it cannot normally be seen but it can be very difficult to live a normal life, their life is different each day. Therefore they can not always plan ahead to fill their days, on some days they may not be able to get out at all. People soon get fed up with them so they become more trapped</p> <p>2) It must still have the two components, mobility and care. Random checks must stay, I even think that everyone on DLA should be seen in person and their identity proved as often as possible. I get DLA without it I would not be able to live a normalish life. Around me on a daily basis I see and hear people getting DLA by lying by omission.</p> <p>3) For me it is a person (not trained) to travel with me, I pay the fares for both of us to go where I need to be. Transport costs, in our area they are taking away Mental Health clients free bus pass. Some services needed have to be paid for as the NHS does not provide them.</p> <p>4) The amount of care a person needs varies greatly so I think there should be more bands not less. Having only two bands would mean there would be a larger difference between them.</p>

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	<p>It would be easier to administer and cheaper for yourselves, but it will push people to exsarate more than they do now.</p> <p>I go to a group each week of people that have Mental Health issues, they rate of DLA that they get indivudly is often disscusted. It is seen as being a unfair system now, be making it only two bands would be seen as being really unfair. It is also true that it depends on who filled the form for you. If it is filled in by a trained person they are likley to get a better award than if the form is filled in by a member of the family or themselves.</p> <p>5) Needs and Circumstances every time. As you have said there is a wide range in the needs for the same illness. Treating everybody the same is fairer, I know a line has to be drawn somewhere but there will never be a fair answer. In Mental Health condisions you can meet a group of clients with the same condision, I can gaurentee they would all have different needs, and most proberly the needs would be different depending on what support they have around them.</p> <p>6) Although the form is too long, it must not become to generalised as the prority for the most disabled would be lost. Instead of the Question can you prepare a meal, which can be answered just yes or no, it should be split down to. Can you buy the ingrediants for a meal. Can you prepare the foods for a meal. Can you use a cooker to cook a meal Can you serve up a meal . Can you carry it safely to the table. Not the correct wording but underlines where the problems are. Support for these people is not just about their care or mobility, which is important, but about being able to do all the things a normal person does, so it is also about prioritiseing with making them able to fit into life. With pisical disabilities mainly it is easy to see what then can or cannot do, with Mental Health it is more difficult. The form is very long but it only has two pages about Mental Health, so therefore they get refusted, or have to go to tribunials to get the money they need to live a basic life, as you cannot judge what thier life is like in a few sentansense. Their reasons for not being able to something, might be able to be done physaly but like climbing a very large wall mentally. By making it so difficult for these people to get DLA some do not claim it as either they have not got the capasity to fill in the form because even picking up a pen is too frightning, but when they have to fight to get it can cause them great ansiaty and panic, and make them very ill, they cannot cope so go without. Which means the people who have the greatest need go without and those with a lesser need but can use their brain to exgagerate get the most money</p> <p>7) With some mental health condisions i.e. Bi Polar, they follow a cycle, to fill in the form you have got to be in a fairly good place, so there should be more time to fill in the form as yhey may have to do it slowly so it does not cause so much stress. Perhaps having two answers to each mental health question what you are like on a good day and what are you like on a bad day. I know for a lot of the users they are ashamed about their condision so they on put down what they are like on a average day. They feel if they put down what they are like on their worst day they are lieing. Perhaps you need to have two differnt forms one for mentally ill and one for phisical ill, with both having a small section for any mental or phisical illnesses not covered on that particular form.</p>
ONLINE116	<p>2) A recognition that mobility aids can help, but do not necessariily mean a person no longer has mobility problems!!!</p> <p>3) Mobility Aids - They are expensive! My Severe mobility problems require me to have a number of different high quality aids - sticks, manual and power wheelchairs - to maximise my ability to get anywhere at all. Walking sticks wear out, wheelchairs wear out, need maintenance and insurance. In order to have a wheelchair that meets my needs it will cost a minimum of £3000. The wheelchair service will not provide this, as I am not a full time user. I also need to fund ramps and hoists to get chair into house for charging and into car. All mobility related equipment is very expensive, as is specialist clothing which wheelchair users need - protective clothing for rain etc, gloves to use manual chairs. Transport costs - i need a car to go anywhere and if I can't park sufficiently closely I must get a taxi. This means my transport costs are far higher than the average person. Without transport I can't get out at all. Because of my disability I need an automatic car, with a high seating position and room in the boot for my wheelchair. This means an expensive car</p>

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	<p>and consequently is not cheap to run.</p> <p>If the above are taken as offsetting my mobility problem, how am I supposed to fund them?</p> <p>Utility bills: Due to my disability I move very slowly and therefore feel the cold even more. I also have to spend large amounts of time at home. I therefore have large heating bills - far larger than before my disability. I have more/longer showers and baths (help with disability symptoms) and therefore use significantly more water/power for this.</p> <p>Shopping €“ most of my shopping has to be done on the internet (thank god for the internet!) and therefore I often have to pay delivery charges, sometimes return postage costs. Some things are cheaper on the internet, but grocery shopping loses out because you can't buy cheap food at or near its sell-by date. I buy more "convenience" foods than pre-disability as I often can't prepare a meal myself.</p> <p>Holidays cost more - can't go for cheap deals because of need to ensure wheelchair accessibility etc.</p> <p>There are many things around the house that I am no longer able to do - cleaning, looking after the garden, general basic maintenance. All these things I used to do in pre-disability days. I have to pay to have these essentials done by someone else (even allowing for help of family/friends)</p> <p>Prescription charges - disability related and so permanent high usage - annual prepayment.</p> <p>The loss of my salary now I am no longer able to work(really!) also constitutes an extra cost in the form of less income</p> <p>4) I think there was a clear rationale why mobility had two rates and care had three when dla was devised. Delineating mobility problems as two discrete levels makes sense and provides a fair encompassment.</p> <p>However care needs are not so simply divisible and I believe that many people will be unfairly assessed if there are only two levels.</p> <p>I am in the middle rate care. There is no way that I would qualify for higher rate care and yet my care needs are significantly higher than the lower rate. Even stretching the cutoffs to incorporate the middle rate into the higher and lower rates will inevitably leave many people wrongly assessed - most likely in the lower category.</p> <p>I do not believe that having 2 rates for the care component will make the benefit simpler to understand - the distinction between the current 3 categories is very clear and there is a huge gap between the needs of higher and lower rate recipients.</p> <p>There is no reason to think a two category care rate will be simpler to administer. Rather, it will be harder I think to fairly assign people to an accurately reflecting category are far easier to describe in it is very clear</p> <p>8) This is an incredible important issue that has the potential to have a highly negative impact on a disabled person's life if the wrong decisions are taken.</p> <p>Obviously if aids/adaptions truly mean an individual's mobility problems no longer have any impact on their life, then of course they should be taken into account.</p> <p>BUT the reality is rarely this.</p> <p>As such, starting with an a priori assumption that having a wheelchair means that a person is mobile is a complete misunderstanding of the reality for many people with mobility problems.</p> <p>To illustrate:</p> <p>I have severe mobility problems. I can walk perhaps up to 10 steps before I must stop and have a break. Each step I take causes significant pain.</p> <p>But, sitting aggravates my condition and so even a wheelchair cannot overcome my disability (so identifying me as mobile because I have a wheelchair is ridiculous!). I need to regularly get out of the wheelchair and move about, causing yet more pain, and slowing any progress in getting anywhere.</p> <p>Before I received my wheelchair, I had thought it would deal with my mobility problems. Even without the above restriction the reality is very different. Using a wheelchair is incredibly difficult (anyone who assumes having a wheelchair solves mobility problems really needs to spend a couple of days in one trying to get on with their usual life). The world is not flat and smooth, so assessing an ability to use a wheelchair inside on a flat, smooth surface is meaningless. Pavements have cambers, bumps, obstacles and kerbs. The world is full of slopes (up and down cause problems), ramps are steep etc etc. If you have a wheelchair you need a car that accommodates it, you need accessible public transport etc. Not everywhere is accessible in a wheelchair yet.</p> <p>Then there is the wheelchair itself. The local wheelchair service provided me with a</p>

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	<p>wheelchair that was too heavy for me and aggravated my back and caused injuries to my shoulders from the efforts of propelling it (classic wheelchair athlete injuries I was told!), meaning it is even more problematic to self-propel. I self-funded a lightweight chair (having to pay 80% of the costs). As I am not a full-time user, I am not entitled to a lightweight chair on the NHS. Nor am I entitled to have a hoist provided for my car, which they recommended I need. Nor am I entitled to a powerchair, again because I am not a f/t user. If regulations assume that an aid solves a problem fully, rather than recognising that it may mere ameliorate some aspects of the problem, people will be discouraged from getting that aid.</p> <p>This is particularly the case when the optimum aid has to be self-funded €“ the NHS rarely provides the optimum aid for an individual, because it is generally significantly more expensive than a standard aid. Aid don t last forever. Disability benefit helps fund the costs of these</p> <p>10) Undergoing a detailed assessment with a new professional is a very stressful experience for many people with long standing disabilities. This is particularly the case given the purpose of this assessment. Any assessment will be much more comprehensive and accurate from someone with a long-standing knowledge/relationship with a patient (e.g. GP, Consultant specialist, physio, OT, S.W. etc. )</p> <p>If you have a long-standing disability that has a negative impact on your life, one of the most helpful ways of managing is to downplay and minimise the effects of your problems. This helpful way of surviving life with a disability is not a helpful strategy when being assessed by a benefits assessor. A professional who knows the true nature of your problems and its impact on your life is far better placed to make a valid and reliable assessment.</p> <p>Considering information from healthcare and other professional who work and know the individual is very different from taking advice from them.</p> <p>In general if the "independent healthcare professional" is employed by a private agency their independence will always be in question. Given the clearly stated aim of the change is to reduce the number of people who qualify for the benefit, any private company employed for the assessments will be under pressure to reduce the numbers who qualiafy for the benefit. This inevitably questions the independence of an assessment done by professionals they employ.</p> <p>Currently information is also sought from a private individual who knows the claimant in a personal capacity on a day to day level. Of course the objectivity of such information is always open to question, but they may often provide crucial information that no one else will ever have access to.</p> <p>It also needs to be recognised that for many people with long-standing conditions/disability that the notion of the expert patient is encouraged and encourages self-management as far as possible. As such, on-going contact with professionals may not happen on a regular basis. Yet the professional they have previously had may still be best placed to undertake a meaningful current assessment as they will have a knowledge of the history and a relationship with the patient to build upon.</p>
ONLINE117	<p>1) CAPABILITY, MOBILITY.  PERSONAL,PHYSICAL AND MENTAL CONDITIONS/ LIMITATIONS.  LEVELS OF PAIN.  COST.  PHYSICAL ABILITY TO USE DISABILITY AIDS.  ABILITY TO CARE FOR ONE SELF.  AWARENESS OF AVAILABLE HELP  DEPENDANCY ON, AND SUPPORT FROM OTHERS.  SIDE AFFECTS OF MEDICATION.  RESPONSIBILTY TO CARE FOR A DISABLED PARTNER OR DEPENDANT  ACCESSABILITY TO BUILDINGS/PLACES.  ABILITY TO COMMUNICATE.  UNDERSTANDING OF NORMAL PERSONS AS TO YOUR NEEDS.  OVERCOMING EMBARRASSMENT.  EXCEPTANCE.</p> <p>2) RETAIN INDEFINATE AWARDS FOR LIFETIME CONDITIONS WHERE IT IS OBVIOUS THERE WILL BE NO IMPROVEMENT.  I.E CANCERS AND HEART DESEASE AND OTHERS</p> <p>3) COST OF CARE.</p>

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	<p>SPECIAL TRANSPORT COST  SPECIAL DISABILITY AIDS,. WHEEL CHAIRS, WALKERS ETC. WHERE APPROPRIATE.  INTERNAL AND EXTERNAL HOME ADAPTIONS/MODIFICATIONS.  MEDICATION.  PURCHASE OF READY MEALS.  MOVING TO MORE USER FRIENDLY ACCOMODATION, ONLY IF DESIRED.  SPECIAL DIETARY NEEDS.  SPECIALIST HOLIDAY ACCOMADATION.  RESPITE CARE.</p> <p>4) YES TWO RATES PER COMPONENT WILL SIMPLIFY CLAIMING FROM THE CLAIMANTS POINT OF VIEW AND THE ADMINISTRATORS SIDE, HOPEFULLY IT BE LESS OPEN TO CONJECTURE.(THE CURRENT MOBILITY COMPONENT ALREADY HAS TWO LEVELS).  THE POSSIBLE DISADVANTAGE COULD BE IF THE VALUE OF THE COMPONENT IS REDUCED DURING REFORM, THIS COULD CAUSE HARDSHIP FOR CURRENT CLAIMANTS.  PERHAPS THE NEW LOWER LEVEL COULD EQUAL THE OLD MIDDLE LEVEL TO RETAIN PARITY OF BENEFIT.  WILL THE NEW SYSTEM BE BASED ON POINTS SCORED REFLECTING LEVEL OF DISABILITY?, AND WILL THIS BE MADE CLEAR DURING THE CLAIMS PROCEDURE?.  IN EXTREME CASES PERHAPS A SUPPLEMENT COULD BE PAID AS AN AUTOMATIC PAYMENT, THIS COULD REFLECT THE MUCH HIGHER COST FOR CARER SUPPORT AND RESPITE CARE.</p> <p>5) YES, WHEN AN INDIVIDUAL HAS BEEN MEDICALLY ASSESSED BY "AN" "OR" THEIR OWN HEALTH PROFESSIONAL AND THEY ARE SATISFIED THE CONDITION IS DEBILITATING LONG TERM, THEIR JUDGEMENT AND THAT OF THE CLAIMANT SHOULD BE ENOUGH TO SATISFY THE CRITERIA, AN AUTOMATIC AWARD SHOULD BE MADE.  TERMINALLY ILL PATIENTS SHOULD HAVE THEIR AWARD BASED ON THEIR HEALTH PROFESSIONALS REPORT ONLY, NO OTHER TYPE OF EXAMINATION SHOULD BE REQUIRED, THIS SHOULD SPEED UP THE PROCEDURE AND IF CARRIED OUT CORRECTLY BE MORE EFFICIENT AND COST AFFECTIVE, AFTER ALL THESE PEOPLE ALREADY HAVE AN INPUT,I BELEIVE AN INDIVIDUALS DOCTOR SHOULD HAVE MORE SAY IN THE PROCEDURE AND IT'S OUTCOME THAN AT PRESENT, THESE ARE THE PEOPLE WHO KNOW A PATIENT MORE THAN ANY OUTSIDE BODY THAT SEES ONLY A SMALL WINDOW OF THE PERSON CONCERNED.  THE INDIVIDUALS HEALTH PROFESIONAL AND THE INDIVIDUAL SHOULD HAVE THE BIGGEST INPUT THIS WOULD FIT IN WITH THE NEW PLAN FOR GP'S TO BE MORE RESPONSIBLE FOR PATIENT CARE, THIS NEED NOT HAVE TO BE DONE BY THE DOCTOR BUT THE PRACTICE MANAGER WHO HAS ACCESS TO MEDICAL RECORDS.  JUST THE DOCTORS PERUSAL AND SIGNATURE SHOULD SUFFICE.  MORE GENERAL DISABILITIES SHOULD BE INDIVIDUALLY BASED AS AT PRESENT. THE USE OF TRAINED CONSULTANTS WILL NEED TO BE APPLIED WITH GENERAL CASES USING A POINTS SYSTEM.  IN OTHER WORDS THIS PART OF THE NEW BENEFIT SHOULD STAY THE SAME AS AT PRESENT.</p> <p>6) FIRSTLY THE CRITERIA SHOULD BE SET, THEN AN OBJECTIVE PROCEDURE USING RELEVANT PROVEN TOOLS SHOULD BE USED.  BASED ON MY OWN EXPERIENCE OF THE CURRENT PROCEDURE I BELEIVE IT IS FAIRLY CLOSE,MY WIFE AND I ARE BOTH DISABLED AND WENT THROUGH THE CURRENT CLAIMS PROCEDURE, AT FIRST IT LOOKED DAUNTING BUT WITH A LITTLE HELP FROM A SPECIALIST CHARITY WE MANAGED TO GET IT RIGHT.  HELP IS THE MAIN THING MOST PEOPLE NEED TO CLAIM, THIS SHOULD BE FROM GOVERNMENT AND NOT RELIANT ON CHARITY GROUPS ONLY.IT SHOULD ALSO BE ADVERTISED.  THE MAIN PRIORITY OF ANY ASSESSMENT PANEL SHOULD BE TO ASSIST THE CLAIMANT TO ACHIEVE THE CORRECT LEVEL OF CARE, NOT TO LOOK AT WAYS OF DEPRIVING THAT PERSON.</p>

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	<p>NOT MANY PEOPLE ARE AWARE THAT JOB CENTRES AND SOME CHARITY GROUPS CAN OFFER CLAIMANT HELP.</p> <p>RETAINING AS MUCH INDEPENDANCE AS POSSIBLE IS THE MOST ESSENTIAL THING, THE MORE INDEPENDANT YOU ARE THE BETTER LIFE YOU CAN EXPECT. MOBILITY, COMMUNICATION, BEING ABLE TO CARE FOR YOURSELF SHOULD BE THE MAIN OBJECTIVE, BASED ON AN INDIVIDUALS ABILITY TO COPE.</p> <p>GREAT CARE SHOULD BE TAKEN WHEN INTRODUCING REFORM, THE MOTIVES NEED TO BE BALANCED AND NOT JUST BASED ON FINANCIAL SAVING OR POLITICAL GAIN.</p> <p>THERE IS OF COURSE THE NEED FOR PRACTICAL HELP WITH SEVERE DISABILITY, PARTICULARLY WITH RESPITE CARE, THIS SHOULD BE TAKEN INTO ACCOUNT WITH THE REFORMS.</p> <p>OUR LOCAL COUNCIL IS CURRENTLY CLOSING DOWN SOME RESPITE PLACES, THIS SHOULD NOT BE ALLOWED, RESPITE IS VITAL FOR SOME CLAIMANTS AND THEIR CARERS AND SEEMS TO BE IN CONFLICT WITH THE PROPOSED CHANGES.</p> <p>7) THE PROCEDURE SHOULD BE BALANCED AND OBJECTIVE.</p> <p>OBJECTIVITY IS PROBABLY THE HARDEST THING TO MAINTAIN, PARTICULARLY IF THERE ARE TOO MANY CONCEIVED BARRIERS.</p> <p>REVIEW CLAIM FORMS COULD BE LESS COMPLICATED THAN THE INITIAL CLAIM, A SIMPLE YES OR NO BASED FORM MAY BE BETTER.</p> <p>AT PRESENT THE CLAIMANT HAS TO GO THROUGH THE SAME PROCEDURE AS FIRST APPLIED, IT WOULD BE LESS BEAUROCRATIC IF THIS CAN BE MORE SIMPLE.</p> <p>ONLY IF THERE IS SIGNIFICANT CHANGE SHOULD FULL RE-APPLICATION BE REQUIRED.</p> <p>THE CLAIMANTS HEALTH PROFESSIONAL SHOULD BE ABLE TO OFFER GUIDANCE ABOUT POSSIBLE FLUCTUATIONS IN A PERSONS CONDITION.</p> <p>I HAVE HEART DESEASE AND SUFFER UNSTABLE ANGINA, THIS IS COMMON WITH MY CONDITION.</p> <p>8) FIRSTLY YOU NEED TO ESTABLISH IF AN INDIVIDUAL CAN USE A SPECIFIC AID OR APPLIANCE.</p> <p>DO THEY ACTUALLY WANT TO USE AN AID, MOST DISABLED PEOPLE I KNOW RESIST THE USE OF AN AID BECAUSE THEY FEEL THEY ARE GIVING IN, THEY SHOULD NOT BE PENALISED BECAUSE OF IT.</p> <p>MY WIFE AND I BOTH STRUGGLE WITH STAIRS BUT WE RESIST HAVING A STAIRLIFT FITTED FOR THE SIMPLE REASON WE FEEL IT IS A GIVING IN.</p> <p>OF COURSE THERE IS THE DEGREE OF PAIN EXPERIENCED.</p> <p>AT PRESENT DEGREE OF PAIN IS PART OF THE ASSESSMENT PROCESS.</p> <p>NOT ONLY IF THEY ARE CAPABLE BUT ARE THEY CONFIDENT.</p> <p>THERE ARE PEOPLE WITH TWO PROSPHETIC LEGS RUNNING MARATHONS, IT DOESN'T MEAN THAT EVERYONE WITH THIS DISABILITY CAN DO THE SAME, AN INDIVIDUALS ABILITY TO COPE IS THE CRITERIA.</p> <p>IT IS IMPORTANT TO REMEMBER THAT MOST AIDS ARE INSTALLED IN THE HOME, THE DISABILITY IS STILL CURRENT WHEN THE PERSON LEAVES THEIR HOME.</p> <p>MY WIFE HAS A WALKING STICK TO HELP BALANCE, A WHEEL CHAIR COULD BE BETTER BUT SHE DOESN'T HAVE ENOUGH GRIP TO DRIVE THE WHEELS.</p> <p>AN ELECTRIC SCOOTER WOULD HELP, SHE HAS POOR VISION AND LACKS THE CONFIDENCE TO DRIVE ONE.</p> <p>WE HAVE NO SECURE PLACE TO LEAVE IT.</p> <p>WE ARE BACK TO THE INDIVIDUAL.</p> <p>I COULD GO ON.</p> <p>9) AS I STATED IN MY PREVIOUS RESPONSE, I BELEIVE THE CURRENT FORM IS CLOSE AND REQUIRES ONLY MINOR CHANGE.</p> <p>THE GREATEST NEED IS THE SUPPORT NEEDED FOR SOME PEOPLE WHO DO FIND THE CLAIM PROCESS COMPLICATED, THIS WILL ALWAYS BE, NO MATTER WHAT THE PROCEDURE IS.</p> <p>I FOUND ANSWERING THE QUESTIONS FAIRLY EASY, EXPLAINING IN DETAIL IN THE LINKED BOXES CAN BE A PROBLEM, IT IS NOT ALWAYS EASY TO PUT INTO WORDS THE AFFECTS AND PROBLEMS.</p> <p>IF THE NEW SYSTEM IS POINT BASED (AS THE ESA SYSTEM) AND THE LEVELS OF AWARD MADE CLEAR, THIS WOULD HELP GREATLY.</p>

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	<p>YOU COULD SAY THIS KNOWLEDGE WILL GENERATE FRAUD, SURELY THIS CAN BE TAKEN OUT IF THE RIGHT TOOLS ARE IN PLACE.</p> <p>THE AWARD IS FOR THE INDIVIDUAL TO MAINTAIN AS MUCH INDEPENDANCE AS POSSIBLE THIS SURELY IS THE BASES FOR THE WHOLE THING.</p> <p>IF YOU REALLY WANT TO IMPROVE THE INFORMATION FOR THIS NEW BENEFIT WOULD BE TO ACTUALLY MAKE PEOPLE AWARE IT IS THERE, OFTEN BENEFITS SEEM TO BE HIDDEN, I HAD THIS EXPERIENCE MYSELF.</p> <p>QUALIFYING GUIDE LINES SHOULD BE PUBLISHED AND EASILY AVAILABLE.</p> <p>ONE OF THE PROBLEMS I HAD WAS FEELING GUILTY FOR CLAIMING, AFTER A LIFE TIME OF WORK IT WAS HARD TO COME TO TERMS WITH HAVING TO CLAIM, I WASN'T SURE IF I WOULD BE ABLE TO CLAIM AT ALL, AND WAS DEEPLY WORRIED HOW I WOULD MANAGE.</p> <p>IT WAS PARTICULARLY HARD FOR ME BECAUSE MY WIFE HAD TO RETIRE FROM ILL HEALTH SO MONEY WAS A REAL WORRY.</p> <p>IF IT IS POSSIBLE TO HAVE SOME KIND OF SIMPLE GUIDELINES AS TO RIGHT TO CLAIM WOULD BE A LOT OF HELP.</p> <p>10) AS PREVIOUSLY STATED, THE INDIVIDUALS DOCTOR OR HEALTH PROFESSIONAL SHOULD HAVE A MAJOR ROLE IN SUPPLYING INFORMATION.THIS ALONG WITH THE INDIVIDUAL, ALSO IN CERTAIN CIRCUMSTANCES FAMILY COULD BE HELPFULL, WE DEPEND ON OUR FAMILY WITH A LOT OF THINGS, HOUSE WORK COOKING PROPER MEALS ETC.</p> <p>ANOTHER ASSESSING BODY PREFERABLY GOVERNMENT CONTROLLED COULD HAVE AN INPUT INTO ASSESSING ABILITY, IN SAYING THAT ATOS WHO CURRENTLY SUPPLY SPECIALIST CONSULTANTS SEEM TO DO A GOOD JOB.</p> <p>THE PITFALL COMES WITH AN OUTSIDE BODY ASSESSING CLAIMANTS WITH A VIEW TO CREATING PROFIT FOR THEIR COMPANY, WITH GOVERNMENT BODIES I THINK THIS IS LESS LIKELY.</p> <p>THE PITFALLS ARE AS NOW, IF THERE ISN'T ENOUGH DETAIL ON THE CLAIM FORM A CLAIMANT COULD MISS OUT ON THE CORRECT LEVEL OF AWARD, ACHEIVING THE RIGHT BALANCE IS NOT EASY.</p> <p>11) THIS ISN'T ACTUALLY NEW,I HAD AN INTERVIEW AS PART OF MY CLAIM PROCESS, IT WASN'T DIFFICULT AS THE MEETING WAS IN OUR OWN HOME.I FOUND IT OF BENEFIT AS IT REMOVED ANY DOUBT AS TO MY LIMITATIONS IN NORMAL SURROUNDINGS.</p> <p>ALSO THE DOCTOR HELPED ME WITH OTHER ADVICE.</p> <p>HOWEVER IF THE INITIAL INFORMATION SUPPLIED IS ENOUGH TO AWARD THE BENEFIT, FURTHER MEETINGS SHOULDN'T BE NEEDED.WHY GENERATE MORE COST AND BEAUROCRACY?</p> <p>THE ONLY TIMES IT COULD BE SEEN AS INAPPROPRIATE IS IF THE INDIVIDUAL IS HAVING TROUBLE COMING TO TERMS WITH THEIR CONDITION, OR THEY HAVE A SHORT LIFE EXPECTANCY.</p> <p>OR HAS SUCH BEHAVIOUR PROBLEM AS TO BE INCOHERENT, OR DANGEROUS.</p> <p>IF A FACE TO FACE MEETING IS FELT TO BE NEEDED I FEEL IT SHOULD BE IN THE CLAIMANTS OWN HOME FOR THE REASONS I HAVE STATED.</p> <p>12) LEVEL AND OR POSSIBLE VARIATION OF DISABILITY, THESE ARE THE CRITERIA.</p> <p>IF THE FIRST ASSESSEMENT IS ACCURATE AND THE LONG TERM PROSPECTS OBVIOUS, SOME CLAIMS NEED NEVER BE RE-ASSESSED, AS NOW.</p> <p>UPDATED INFORMATION FROM THE CLAIMANTS HEALTH PROFESSIONAL WOULD BE USEFULL.</p> <p>IF A RE-ASSESSMENT IS NEEDED THEN I BELEIVE A SIMPLER RE-CLAIM FORM COULD BE USED, A SIMPLE YES OR NO QUESTIONAIRE PERHAPS.</p> <p>THREE OR FIVE YEARLY COULD BE THE A GUIDE,UNLESS IT IS OBVIOUS THAT THE DISABILITY WILL BE SHORTER OR LONGER, EITHER FROM SURGERY OR NATURAL HEALING, MUCH LIKE NOW. OTHERWISE THE SYSTEM WILL BECOME MORE COSTLY AND TIME CONSUMING.</p> <p>IF THE INDIVIDUALS NEED HAS CHANGED SIGNIFICANTLY A COMPLETE RE-ASSESSMENT MAY BE BETTER, THIS WOULD BE INDICATED ON THE INITIAL REVIEW FORM.</p> <p>13) IF THE INFORMATION IS EASIER TO SUPPLY THEN MOST PEOPLE I BELEIVE WOULD SUPPLY IT.</p>

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	<p>I NOTICE YOU ONLY STATE FOR IMPROVED CONDITIONS YOU HAVE NOT ALLOWED FOR THE OPPOSITE.  MY WIFES CONDITION HAS DETERIORATED BUT THE PROCEDURE OF RE-CLAIMING IS OFF PUTTING.  OF COURSE THERE IS ALWAYS THE FEAR OF LOSING THE MONEY, IF THE INDIVIDUALS ABILITY HAS IMPROVED RATHER THAN STOP OR REDUCE THE AWARD INSTANTLY PERHAPS IT COULD BE TRANSITIONAL.  THERE HAS TO BE AN INCENTIVE IN ORDER TO REDUCE POSSIBLE DISHONESTY. IF THE THREE OR FIVE YEAR PERIOD FOR RE-ASSESSMENT IS IN PLACE THEN MOST CASES WOULD SHOW UP.  PERHAPS A SIMPLE YEARLY QUESTIONNAIRE COULD BE USED.  PAPER OR E/MAIL GENERATED.  HAS YOUR CONDITION IMPROVED OR DETERORATED OVER THE PAST YEAR, ANSWER YES OR NO.  THEN WHATEVER PROCEDURE COULD GO FROM THERE.  I CAN'T SEE A SIMPLE WAY OF PREVENTING FRAUD, THERE WILL ALWAYS BE PEOPLE WHO TRY AND CHEAT THE SYSTEM.  14) WHAT BENEFITS ARE AVAILABLE.  HOW DO YOU OBTAIN CLAIM INFORMATION AND FORMS.  WHAT HELP AND WHERE CAN YOU GET IT TO HELP APPLICATION FILLING.  WHAT APPLIANCE/AIDS ARE THERE AND WHERE CAN YOU GET THEM,  I HAVE FOUND THE BRITISH RED CROSS VERY HELPFULL INDEED, ALSO THEY ARE NOT TO COSTLY.  CARER INFORMATION.  SUPPLY OF READY MEALS.  LIST OF LOCAL RECOGNISED TRADESMEN TO FIT ADAPTIONS.  HOW TO OBTAIN RESPITE INFORMATION FOR CLAIMANTS AND CARERS.  INFORMATION FOR CHILDREN CARING FOR A SIBBLING OR ADULT WOULD BE USEFULL, THERE ARE A LOT OF SILENT CARERS WHO ARE CHILDREN.  15) THIS IS MOSTLY COVERED IN 14.  THE MORE ADVICE AND SUPPORT THERE IS THE GREATER THE NUMBER OF REPOSE.  THE HELP SHOULD BE FREE.  AS IN LIFE, KNOWLEDGE IS A KEY TOOL.  OVER COMPLICATION AND BEAUROCRACY ARE THE MAIN THINGS TO AVOID.  HUMAN RIGHTS ISSUES COULD BE A PROBLEM IF SOME KIND OF COMPULSARY REQUIREMENTS IS FORCED ON THE CLIENT.  16) FROM MY OWN EXPERIENCE INITIALLY BECAUSE I WAS STILL WORKING I COULD AFFORD THE COST MYSELF, ONCE WE WERE AWARDED DLA WE USED THAT MONEY TO PURCHASE AND PAY SOMEONE TO FIT THE ADAPTIONS WE HAVE.  IF BY THE SECOND PART OF THE QUESTION YOU PROPOSE TO PAY FOR ADAPTIONS AS A ONE OFF AND THEN NOT PAY ANY BENEFIT, I BELEIVE THIS SHOULD BE LEFT TO THE INDIVIDUALS.  AS YOU STATED IN THE EARLIER CHAPTERS, THE PROPOSAL IS TO MAINTAIN THE WAY THE BENEFIT IS PAYED, IE' IT IS FOR THE INDIVIDUAL TO DECIDE HOW BEST TO USE THE AWARD.  IF YOU ARE DISABLED THEN PRACTICALLY EVERYTHING COSTS MORE, THERE ARE ALWAYS SURPRISES WHICH INVOLVE ADDITIONAL COST. BUT ADAPTIONS THOUGH USEFULL DON'T REPRESENT A CURE.  17) DEALING WITH CHILDREN HAS IT'S OWN COMPLEXETY, IT IS DEPENDENT ON AGE AND ABILITY TO COMMUNICATE, AS WITH SOME ADULTS,THIS CAN ALSO BE AFFECTED GREATLY BY THE TYPE OF DISABILITY.  THE AWARD REALLY HAS AS MUCH TO DO WITH THE OVERALL AFFECTS ON THE FAMILY AS IT DOES WITH THE CHILD.  OFTEN A FAMILY MEMBER MUST STOP WORKING IN ORDER TO CARE FOR THE CHILD, SO THE BENEFIT ALONG WITH CARERS(IF APPLICABLE) ALLOWANCE WOULD BE USED NOT ONLY TO SUPPORT THE CHILD BUT ALSO RIGHTLY OR WRONGLY REPLACE INCOME.  WITH CASES OF CHILDREN THEIR HEALTH PROFESSIONAL AND OTHER BODIES INVOLVED WITH THE CASE SHOULD HAVE A GREATER PART TO PLAY,</p>

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	<p>PARTICULARLY IF THE CASE IS COMPLEX, I.E. SEVERE DISABILITY.  ALSO THE FAMILY NEEDS TO HAVE AS MUCH INPUT AS POSSIBLE, THEY CAN BE MORE AFFECTED THAN NORMAL CASES INVOLVING ADULTS.  I KNOW OF TWO CASES OF YOUNG CHILDREN BEING DISABLED, ONE HAS SEVERE DOWN SYNDROME AND THE SUPPORT FOR THE CHILD AND FAMILY ARE CLOSELY LINKED, THE MOTHER IN THIS CASE HAS A FULL TIME CARERS RESPONSABILITY.  THE SECOND CASE IS A CHILD WITH TYPE 1 DIABETES, HE REQUIRES A LOT OF CARE BUT NOT TO THE LEVEL OF THE FIRST CASE.  IN BOTH CASES THE CHILDS DOCTORS/NURSES/CONSULTANTS HAVE HAD A LARGE INPUT, THEIR EXPERTISE HAS BEEN PARAMOUNT.  PERHAPS A SEPERATE TYPE OF CLAIM FORM COULD BE USED.  THE CHANGING AGE OF THE CHILD CAN BE IMPORTANT.  PERHAPS THERE SHOULD BE BUILT IN AGE RELATED ASSESSEMENTS.  INCREASED FINANCIAL AND PRACTICAL HELP SHOULD BE MADE AVAILABLE,OBVIOUSLY THERE MUST BE A LIMIT.  THE ADDITION OF RESPITE CARE IS A SERIOUS CONSIDERATION.  THE COST OF KEEPING A CHILD IN LOCAL CARE IS FAR GREATER THAN IF THE PARENT IS PROVIDING THE SUPPORT, SO THIS MUST BE GIVEN SERIOUS CONSIDERATION WHEN REFORM IS IMPLEMENTED.  ?) FROM MY LIMITED KNOWLEDGE AS AN END USER,ON THE SURFACE, THERE DOESN'T SEEM THAT MUCH CHANGE.  THE GREATEST FEAR IS IF THE GOAL POST'S ARE MOVED TO FAR THEN CURRENT CLAIMANTS, MYSELF INCLUDED, COULD BE FORCED INTO FINANCIAL HARDSHIP SIMPLY FROM CHANGE, NOT BECAUSE THEIR DISABILITY AND LIMITATIONS HAS CHANGED AT ALL.  I WOULD LIKE TO SEE THE CHANGES INTRODUCED FOR NEW CLAIMANTS ONLY.  ?) I DON'T HAVE THE KNOWLEDGE TO EXPRESS A WIDE OPINION.  I DO HOWEVER KNOW THAT SOME CASES WHERE A PERSON HAS HAD TO STOP WORK CAN CLAIM INCAPACITY BENEFIT,OR ESA AS THE LATEST CHANGE, MY WIFE AND I ARE BOTH IN THIS BRACKET, HAVING BEEN FORCED TO MEDICALLY RETIRE.  THESE ARE TWO BENEFITS WHICH COULD BE SAME ASSESSED, THIS WOULD BE MORE EFFECIENT AND COST SAVING.  ALSO THE PROCESS FOR CARERS ALLOWANCE COULD BE CROSS LINKED.  I DON'T SEE A PROBLEM WITH SHARING INFORMATION BETWEEN VARIOUS GOVERNMENT OFFICES, ANYTHING WHICH IMPROVES EFFECIENCY HAS TO BE GOOD, PROVIDING IT IS NOT FOR THE BIG BROTHER APPROACH.  ?) THE BIGGEST PROBLEM WOULD BE ADDITIONAL COST,THE ABILITY TO USE THE MOBILITY COMPONENT FOR A CAR.  A LOT OF OTHER HELP IS FREE, I.E THE BLUE BADGE SCHEME, SOME FERRY AND BRIDGE TOLLS, LOCAL FREE SHOPPING TRANSPORT.  IF THIS HELP IS WITHDRAWN IT COULD CAUSE MORE DISABLED PEOPLE TO REMAIN HOUSEBOUND AND LOSE INDEPENDENCE.  ?) I CAN'T SEE ANY IMPACT.  THE ONLY AREAS I WOULD LIKE TO SEE DISCOUNTED IS ANY CONDITION WHICH IS BROUGHT BY SELF INFLICTION I.E DRINK AND DRUGS.  I AM NOT SURE IF THIS FALLS IN THE AREA OF DISCRIMINATION.</p>
ONLINE118	<ol style="list-style-type: none"> <li>1) The non-physical disabilities (mental illness) are often the more problematic - it is important to listen to a professional opinion about how an individual's life is effected and thereafter note any changes that might reduce the dependency on DLA.</li> <li>2) all ok - from a practitioner's point of view</li> <li>4) The 3 and 2 rates work well - I wonder what the cost would be to change this - and is it necessary?</li> <li>5) no automatic entitlement - should be based on circumstances at the time and reviewed</li> <li>6) Severe and enduring mental illness - to be able to get up in a morning / get out of the house / have quality of life which can be simply purchasing food for the day /</li> <li>7) Severe and enduring mental illness - regular reviews / accept the judgement of the individual's professionally qualified worker.</li> <li>8) Yes</li> <li>11) Severe and enduring mental illness - you should ensure that the healthcare</li> </ol>

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	<p>professional has an understanding of the individual's needs from a practical point of view - perhaps an Approved Social Worker who is qualified to assess people with severe mental illness and also has training from a social care perspective</p> <p>12) A request to the individual's professionally qualified key worker for an update - and then to accept that person judgement</p> <p>13) as 12</p> <p>?) Yes - good idea</p>
ONLINE119	<p>1) Mobility. The ability to get to places that public transport does not service, bus services are being scaled back to major routes all the time especially in rural locations, for gods sake keep the higher rate mobility component, or divide it so that people on the lower rate could get a small vehicle, and those on the higher rate have the ability to get a larger one, for example to get a wheelchair into. I live in a rural location, and my motability car lets me keep down a job I could not get to with public transport, and it gives me independence I simple would not have. I can take my kids out and feel that I can contribute to them some of the help they give me. Please don't take that away, it would be cruel.</p> <p>5) Yes, I believe Spinal Conditions &amp; Arthritic conditions should mean automatic entitlement. These conditions are 'rest of life' conditions, and the constant worry of future governments removing the help we receive is torture.</p> <p>6) Mobility. The ability to get out and about. Without this you force people into a reclusive existence, it isn't nice.</p> <p>8) None, if you need aids or adaptations then you cannot cope normally and are just 'making do' with things you can find to help. Assessments should be from a baseline, and not taking into account existing aids, as the need, or availability of new or more useful aids might be missed if you include existing aids.</p> <p>9) Why force people to keep re-applying. If you are entitled to DLA, then upon renewal a statement from your doctor showing how anything has changed should be sufficient, your doctor is not going to lie, so why force us into oral hearings and tribunals, it seems as if you just dont want to help and are putting up barriers to try and force us to back down. I have a spinal issue, which your own DLA doctor, my surgeon and my GP has said is inoperable and will worsen with time, so why do I have to keep being reassessed all the time, three experts have given their opinion, why do you not believe them ?</p> <p>10) The persons own GP, for gods sake thats the person they see all the time, they MUST know how you are. Why force us to see DWP doctors that have not a clue about you or how you can or can't cope.</p> <p>11) We already have them, they are called General Practitioners, they know all about us, why do you not believe their input, are you calling them liars ?</p> <p>13) Simple, listen to what people say. You ignore letters telling you we have got worse, you do not resp[ond], or you take away the benefit completely and tell us to reapply , any suprise we dont get in touch ?</p> <p>?) good idea</p> <p>?) not important, VITAL. Without my vehicle I could not get to work, so would be stuck on other benefits, my car keeps me mobile so delays the advance of my conditions, it gets me to airports so I can 'take' my kids away, it neutralises the disadvantages society throws at disabled people and puts us on a more even playing field.</p> <p>?) PLease dont take away the only thing society gives us to help make us equal. Care component helps make compromises around the home that lets us cook food, or prepare meals, mobility gets us to work, and keeps us alive, take them away and we become dependant vegetables, thats a fact, dont condem us to a life shut away, we have shown faith in you and your government, please do the same back.</p> <p>?) Simply make the process less 'heavy'. Have a set of conditions that mean you qualify, Arthritic spinal conditions etc, and then look at what help you can put in place to allow people to cope day-to-day.</p> <p>Accept there will always be benefit cheats, but they are such a small percentage that its not a major issue. The people who benefit massively outweigh the idiots.</p> <p>Get a GP's letter stating if the person has a qualifying condition, they will know the person long term so are better placed than DWP doctors to make decisions.</p> <p>?) They would miss out on so many things, and once again you would introduce the two tier system of those with abilities having a better lifestlye than those without.</p> <p>?) Why can information not be shared, surely if you have nothing to hide, then this can just be an advantage ?</p>

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ONLINE120	<p>1) Many barriers are psychological such as not wanting to be seen as different(I hate going into golf clubs and gyms) or being ignored by others who often it seems are embarrassed and uncomfortable talking to you.</p> <p>Transport is the most difficult issue especially if you live outside of major towns where a car is essential if you want to take part in the world. I am a member of a number of NHS and Charity committees and could not do this without my Motability car.</p> <p>Accessibility to buildings and services, although improving, is still a problem. In the small town that I live none of the restaurants have accessible toilets which means that we have to travel somewhere if we want to go out for a meal.</p> <p>2) This part of the proposal seems acceptable</p> <p>3) Transport is a significant cost.</p> <p>Physiotherapy as the NHS does not give this to the long term disabled</p> <p>To do jobs at home that are usually classed by the non disabled as DIY require the employment of someone. For example putting a draft excluder on the bottom of a door or putting up a curtain rail are impossible for me and the labour costs far exceed the cost of the part being fitted.</p> <p>this also applies to gardening</p> <p>Food costs can be higher as I cannot prepare vegetables etc and have to use ready meals.</p> <p>Heating, many disabled people suffer from the cold due to a lack of physical activity</p> <p>4) Having 2 rates should be positive as long as the criteria being used to decide which level is applied is very clear and seen to be fair and equitably applied throughout the country. It is important that it does not end up as a post code lottery as with the NHS</p> <p>5) Possibly someone with a terminal illness should receive it automatically but otherwise all claims should be based on the persons needs</p> <p>6) Shopping for food and basic needs</p> <p>Activities to maintain living accomodation such as cleaning, washing/ironing clothes, etc., making bed</p> <p>Personal care</p> <p>7) It would make life more difficult and result in some people missing benefits</p> <p>8) I don't think this should be taken into account as an aid that can be used by one person is not necessarily acceptable to another with exactly the same condition perhaps because they don't have a positive attitude.</p> <p>It is difficult to define what is an aid. Would a Motability car be classed as an aid? It is for me but I can only have it because I receive DLA</p> <p>10) I think that a statement by a therapist/s who knows the claimant should be required as supporting evidence.</p> <p>This should cover physical,cognitive and speech capabilities as well as general mood and ability to cope with life</p> <p>?) Either from grants from various sources or from their own funds.</p> <p>It could be useful to be able to use the Payment for a one-off cost</p> <p>?) In my experience it has been very useful.</p> <p>Provision of as much information as possible of these extra benefits would help</p> <p>?) The best solution is to have an advice line with a freephone number. Websites can be helpful but the internet is not used by many disabled people</p> <p>?) I do not think it would make any difference</p> <p>?) You could send every recipient a document every 1/2 years asking them to confirm if any changes have taken place. However the cost of this would possibly exceed any benefits</p>
ONLINE121	<p>3) the cost of items such as wheelchairs/ scooters to the individual needs of the disabled person, is not widely met at present, and can only be bought if on highest mobility payment, this stops a great number left relying on savings or other means.</p> <p>4) as long as the tests for each level are clearly defined,example, 'can you walk at all' this question is not easy to answer, it depends on what one regards as walking ?</p> <p>5) easy answer no</p> <p>all claims should be on own merit.</p> <p>8) if the DWP was also in some control of the need and recommendation of such items through therapists or medicals within the tests,</p> <p>9) there is too many questions that repeat themselves within the present three part form,</p>
ONLINE122	<p>1) The attitude of people, lack of funds for mobility (see 2 below), adequate and affordable housing, lack of enlightened employers and employment opportunities and accessibility to</p>

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	<p>buildings, transport, health care and general opportunity that others take for granted. Institutionalisation, poor health, isolation and all the health and other risks associated with it, this is it.</p> <p>Local authorities have been slowly cutting fees and expect a lot of essentials to be funded by the individual.</p> <p>I offer two 'live' case studies from those we support by way of example:</p> <p>1. R is a 56 year old lady with Down's Syndrome and associated health conditions, which means she is only able to walk short distances without tiring. She hates using a wheelchair. R lives in a residential home in a rural location which she loves and she visits her 94 year old mother 50 miles away on a weekly basis. These trips are so important to R and her mother who quoted 'the only reason I am still alive is to see my beautiful daughter, she is my life'.</p> <p>The funding local authority does not contribute anything towards the cost of her transport as the expectation is that this could be met through her DLA mobility payment; she is on the low rate. From this payment, R contributes 50% towards for the house car and driver which she shares with 8 other residents. She then pays 23p per mile for any journeys. These journeys include accessing the community, GP and other medical appointments, leisure, work and social activities. Being an active citizen is very important to R who is very sociable. There is no public transport where she lives and she relies on the car for all her mobility needs. She does not receive any contribution to the cost of transport from the funding authority so R's travel is already being heavily subsidised by the provider.</p> <p>2. A receives £75.80 in DLA mobility every month. The provider retains 22% of this (£16.68) which is his contribution towards the general maintenance of the home vehicle and also paying for the staff member who will be driving. He shares this car with 7 other people. The remainder of his DLA mobility (£59.12) is then paid over to A for his use to cover transport e.g taxis and mileage on house vehicles. If A were to stop receiving his DLA mobility benefit, the £16.68 retained for running a house vehicle would either have to be deducted from his personal allowance or the home could no longer afford to own its own vehicle. The LA does not contribute towards transport despite this being on the CFC. At the moment to access transport to educational, cultural and developmental activities A spends on average per month £100 on cabs and mileage. The activities he is attending are part of his assessed support package and largely prevent episodes of challenging behaviour which have been an issue in the past. Most providers of these activities cannot afford to provide transport for the cost they receive per session. The amount it costs for transport cannot currently be met out of his DLA mobility alone, therefore he dips into his personal allowance of £89.20 per month which also has to fund his toiletries, haircuts, chiropody treatments as well as his holidays and clothing which have also been withdrawn from his LA funding.</p> <p>Removing the mobility component of DLA would seriously impinge on choice, access to meaningful activities and in turn would lead to an increase in behavioural challenges. This would increase his support costs considerably as he would require more 1:1 support at a cost of around £20 per hour, he may revert to needing specialist support from psychology and community based education.</p> <p>Behavioural support for A depends on access to meaningful activities so he is engaged, learning new skills, building confidence and improving communication so that he can be an active citizen within the community.</p>
ONLINE123	2) People with disabilities do not want or need any changes to the scheme, to obtain D.L.A. takes time effort and the help of your G.P. or other professional medical person or persons.
ONLINE124	<p>1) Send them an automatic letter every now and again, asking them if any of their circumstances have changed?</p> <p>2) I dont really understand the question, however it would seem sensible to give them all the advice &amp; information from the start when they first enquire</p> <p>3) Not sure, dont understand</p> <p>4) With benefits obviously. yes would make sense</p> <p>5) Assessing children for what? Question doesn't explain anything, obviously age / disability etc should be looked at ??</p> <p>6) Helps them with functioning day to day, wouldnt know how things can be improved as im not personally disabled, and dont know what passporting arrangements are</p> <p>7) Not sure</p>

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	<p>8) Dont know about other benefits so i wouldnt know, but would make sense giving most people a medical exam and checking doctors views etc on disability.</p> <p>9) Wouldnt know</p> <p>10) I have no idea what the proposals are, what this public consultation is supposed to be, or even what Personal Independence Payment is. I dont understand anything being asked, have not even had a brief what these questions are supposed to be about, so this just seems like an hour wasted. So I apologise for my answers being somewhat useless to you, but it would help if we were explained what i am even answering questions about!</p>
ONLINE125	<p>1) As a Visually Impaired person who now works, but has spent time unemployed, I have some experience of the barriers disabled people face. For Visually Impaired people the main barriers are travel costs and equipment/daily living aids that allow full interaction with society. These can be expensive.</p> <p>2) The mobility component is crucial to Visually Impaired person due to the extra costs related to getting around on public transport compared to a car. For example I travel by train to work at peak times. It is 22 miles door to door. That in an average small car be £27.50 worth of fuel, I pay £32 a week for my train ticket. Instantly I need £4.50 per week more, and then add going shopping, travelling between friends houses etc. Although the free bus pass makes a difference it does not negate all the extra costs, I have estimated that I spend an addition £20 a month to travel compared to if I had a car. I also feel the different tiers; Low/Mid/High should remain. This makes DLA easier to process and allows for easier classification of customers needs and therefore costs.</p> <p>3) Visually Impaired people have extra costs related to travel, outlined inQ2. Also there are extra costs related to daily living aids not covered by Social Services such as talking watches, Braille stickers and not forget software for PCs to make them accessible.</p> <p>4) I do not consider that 2 rates for each component would allow a fair deal for our customers. The same health issue can have differing levels of effect on people and just 2 rates would not demonstrate this. It is easy to grasp a 3 rate system when dealing with customers as it allows us instantly to have a picture of how someone is effected by their health issues.</p> <p>5) I do not think any health issues should grant an automatic entitlement to any benefit. However a large number of health issues are permanent and having to €œre-apply €□ is not appropriate. My Visual Impairment will never get better, only worse and so my current DLA reflects my current needs which will not lessen over time but my needs will be greater.</p> <p>6) We need to prioritise activities that are most effected by most health issues, travel and €œcare €□. I say €œcare €□ as it encompasses many aspects of life such as breakages due to accidents, additional dietary needs, additional clothing, the list is extensive. We should prioritise according to greatest additional costs as this would reflect how much of an impact their health issues impact their life and allow them to lead a fuller, €œnormal €□ life.</p> <p>7) It is only possible to ask someone how they are on their worst days. It would be too costly to hold frequent assessments for someone with a fluctuating conditions.</p> <p>8) No. There are very few aids that can be funded by Social Services or DWP for the home. Currently customers are meant to use their DLA for this. Unless a grant for aids is introduced in addition to PIP assessing someone with aids would discriminate against them, as someone without aids could be awarded more based on their assessment.</p> <p>9) This ties in with the idea of face to face interviews. I believe it would be more positive if the application was done by phone rather than form. This would save time in the application process. Also there would be opportunity for a customer to receive clarification if they have any doubts about what to say/write, especially since in practice Jobcentres staff neither have the time or training to fulfil our commitment to help people fill forms in.</p>
ONLINE126	<p>1) Problems and barriers come in 2 different forms. Firstly people's attitude, which are outwith the scope of this consultation.</p> <p>Secondly, access to aids, equipment and care needs-which have financial implications. For example, I use an electric wheelchair, specialised speech recognition software and drive a wheelchair accessible vehicle. My wheelchair is supplied by NHS Tayside. My specialised speech recognition equipment, for work, was paid for by Access To Work (although I have also purchased this equipment privately, for my own PC-fortunately the US suppliers offered it at 20% of the normal cost).</p> <p>I also drive a wheelchair accessible vehicle, even on the cheapest option, Motability 5 year contract hire-this vehicle cost over 12000 pounds-over and above my mobility component</p>

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	<p>of DLA. Access To Work contributed around 2800, however, that still leaves me with a commitment of at least 10000 pounds every 5 to 7 years.</p> <p>My care needs revolve around someone being on hand, in case I need assistance and also help with food and drink. Actually, it's more than help, since I need food and drinks prepared for me and placed in the correct position (I could not move a mug of tea, for example, without spilling it.</p> <p>My disability also means, in some circumstances, it is to tiring to drive home for lunch, and then drive back in to town, therefore I will choose to eat out.</p> <p>3) Again mobility and care costs. Examples are electric wheelchairs, cars with modifications, especially wheelchair accessible vehicles and additional adaptations (adaptions to allow disabled people to drive, secure wheelchairs within the vehicle etc).</p> <p>Also care costs, such as preparing meals and drinks and generally just needing someone around because you cannot predict when you require help. Care costs can be difficult to estimate, as quite often the carer is a family member. However, several years ago my carer was unavailable, owing to a minor stroke, and the cost of the care supplied by my local council was far greater than the care component of DLA.</p> <p>4) I'm not convinced that the current number of rates is difficult to understand. What will happen to current claimants on the low rates. If the number of current rates is the best way to provide the appropriate help, then why change it (unless the main reason is to achieve a 20% saving)?</p> <p>8) Aids and adaptations should not be included in any assessment. The example of improving a wheelchair in the mobility assessment seems ridiculous. If someone uses a wheelchair, self propelled or electric, then that person faces additional problems. Access to buildings, including their place of residence, increased transportation costs etc.</p> <p>If I was to worry about anything specific in this document, then it's the suggestion of including aids and adaptations in the assessment, especially wheelchairs in the mobility assessment. For example, if because I could travel a certain distance in my electric wheelchair, that meant I would not qualify for the mobility component, then I could not hire my vehicles from Motability, lose my blue badge. It's simple-if a person cannot walk, they face additional transportation costs. Any suggestions otherwise are absurd!</p> <p>12) While I can see the sense of periodic reviews, for a large proportion of clients, with permanent disabilities, could this not end up wasting money and putting some people through unnecessary stress? ?) I can only respond from personal experience. I fund my car using my allowance plus my own money. Using the allowance to meet a one of cost, seems to not make sense. If I used my allowance to fund the additional costs in converting and adapting my vehicle, then I would not have the allowance to pay for the contract hire. A better proposal would be an allowance that covered the cost of the car hire but statutory funding for adaptations over and above this, where there is a PROVEN need. Yes there are grants available from Motability but these are severely means tested. Even a half way house would be preferable. If you need additional help it's means tested up to a certain figure, say 5000 but everyone is assisted over that.</p>
ONLINE127	<p>1) inadequate benefit and the rising cost of going out to restaurants and cinema etc 2) having the care part low middle high and motability low high 3) High fuel cost which means extra money is going on filling the car and less money going on essentials. 4) you have to have three rate with the care component as being disabled the care can vary in need.the mobility part needs a low rate and high rate and the mobility part must cover motability. 5) Some conditions like what i have is for life(chronic fatigue syndrome)and to be get tested every two years cost the government money and also the worry caused to the disabled person 10) the claimants doctor and specialists 11) healthcare professionals are not trained in specific conditions like M.E. and if they go against a specialist and if the claimant takes his case to an appeal the panel will go with the specialist than a healthcare professional</p>

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	<p>12) if a person has a condition for life then they should not be reviewed</p> <p>? ) Very important</p>
ONLINE128	<p>1) Lack of support for mobility for those who are unable to move around on their own. Need for allowances for mobility even when you are resident in a care home to allow participation in society</p> <p>2) Mobility allowance for those in a care home</p> <p>3) Cost of carers and mobility when wishing to visit friends or family. Cost for family visiting person in care home</p> <p>4) It seems to me that you have the same people writing this new proposal that wrote the original, their is no real change its is still based on ability and mobility rather than need.</p> <p>5) The question is should someone who is quadriplegic and epileptic have to apply when all they can actually do is communicate verbally, seems to me that the scope for automatic entitlement should be widened to encompass those who are unlikely to be able to 'work' but who wish to participate in life.</p> <p>6) You don't prioritise since that implies that there will be people who are least able who will lose out. Activities: Being able to go out and enjoy themselves as much as possible as any able bodied person would wish to do - cinema, theatre, pub and other local activities</p> <p>7) You need to be able to assess an individual continuously over the period of variability, its no good assessing them on a good day and missing out how severe their problems are on a bad day. Suggest that the assessors should stay resident with them for 6 months</p> <p>8) All aids and adaptations should be included as part of the cost of care. The cost of maintenance and replacement should also be included in the overall care bundle. Improvements in technology occur continuously and they must be considered when appropriate</p> <p>9) Have a single A4 sheet which says I wish to apply for PIP, after all you are going to assess them so anything more is a waste of time unless there is the intention of nodding the form through as now. Information: Make sure that the benefits involved do not affect the persons right to continue to receive if they are able to commence work - AKA do not remove £1.1 for every pound earned!</p> <p>10) Current carers and families are best placed to indicate ability. After all its not about ability but the psychology of the person as to whether they are able to do anything at all</p> <p>11) Provided the professional is prepared to stay with the assesee for a period of days/weeks to make a proper assessment then there is no problem. If not then it is pointless. The person being assessed must be comfortable with the location, the professional will have to accept that they will have to go to the person rather than the other way round.</p> <p>12) Current state - if they are unlikely to recover then perhaps no review If they are likely to get worse/better then perhaps ever 6 months Different reviews - yes of course there should</p> <p>13) Once the bureaucrats have their hands on it its unlikely to be simple, after all if its simple they are out of a job. Think like Microsoft, make the systems difficult to use and you have a job for life. Accept you cannot and put it down to experience! After all you may think there is a change but the individual may not, you need criteria to assess change and an individuals ability to measure subjectively against that criteria will be impaired by their mental as well as physical ability and training.</p> <p>? ) Actually I was going to say no comment but that isn't true, PCT's are currently cutting back and as such the more vulnerable are seen as the easiest target to save money. This needs to stop and a more balanced approach needs to be taken. However, I don't necessarily think this is directly related but it is indirectly in as much that it comes down to funding.</p> <p>? ) All costs should be provided through PIP for everything needed to adapt or provide aids. ? ) Children are malleable and are able to cope but they need support as do their parents. The longer you leave it the less likely that they will be able to work around their problems and the more costly it will become.</p>

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	<p>Spend £1 now to save £100 later IMHO</p> <p>?) Everything has a relationship, if you receive the maximum under PIP and it still isn't enough you need to be able to go somewhere for additional funding.</p> <p>I suspect that there will be no difference if it was dropped in DLA and then you would need a further layer of bureaucrats to administer and give out the largess AKA It would cost a lot more</p> <p>?) I don't think it will necessarily affect equality in the groups listed unless some current benefit is removed AKA Mobility for care home residents.</p> <p>In which case you need to explain why someone in a care home shouldn't have a mobility allowance!</p> <p>?) It won't cost less.</p> <p>It is a proposal to move layers of NHS redundant staff to an alternate post as assessors. No one has clearly explained exactly what is going to be achieved in quantifiable terms - what I would expect is that the cost will remain the same whilst increasing the monies available to individuals increases.</p> <p>I would also expect that someone somewhere will be looking at this statistically to ensure that their is a cost benefit rather than cost neutral.</p> <p>You cannot get blood from a stone but you can squeeze the human being until the eyes pop out - oops blind now what benefits am I entitled to!</p> <p>?) Provide as part of claim - not really since all they should do is claim on a single A4 sheet.</p> <p>What do I need to qualify for this benefit?</p> <p>How much will I get?</p> <p>When do I get it?</p> <p>Do I need a bank account - if so then you must be prepared to set one up for them as they may never have had one.</p> <p>?) Why should you have more than one assessment? Assess once and then you should be given access to ALL benefits/services based on that without question.</p> <p>You shouldn't need to share its one department for everything surely!</p> <p>Reduces the bureaucracy and cost and manpower - that won't go down too well!</p> <p>The only need is for an appeals procedure.</p> <p>?) You need to provide pro-active advice yourselves and not leave it to the individual to seek it out.</p>
ONLINE129	<p>1) My 21 year old daughter has Downs Syndrome and is also registered blind. Because of her learning difficulties she is very vulnerable. In order to live with a measure of independence she will need continuing good quality support. Her very poor eyesight limits her options for getting around. She has learnt to travel on two routes with support from Action for Blind People who helped her by planning the safest route and teaching her strategies for recognising where she is. If she needs to learn a new route then she will need this type of support again. Her ability to communicate with others is also limited</p> <p>5) I am a little wary of the term "targeted". Sometimes targetting criteria can disadvantage some people who just miss out if these are applied rigidly. Circumstances for an individual can change rapidly so that a degree of flexibility and that rare commodity common sense needs to be applied. At the very least you should consider fast tracking claims for the illnesses in the current list so that changing circumstances can be accommodated</p> <p>6) 1) Looking after yourself. Buying and preparing food to ensure a healthy and balanced diet, recognising when you are ill and need to see a doctor, using the telephone, taking care of your finances, being safe at home and in the wider community.</p> <p>2) Getting around. See my response to question 1 for more details about this</p> <p>3) Communication. This will be particularly important for the assessment process. The people carrying out the assessments will need to be very skilled in communication with people with learning difficulties. My daughter has significant difficulties when asked a direct question - she either chooses the last option mentioned when asked to choose or if she feels under pressure she will give the answer that she thinks the questioner wants to hear or she will retreat into "I dont know". For many people with learning difficulties it is essential that they are supported by someone who knows hem well.</p> <p>7) With great care! The assessors will need to take a broad view of how these types of conditions affect peoples ability to live an independent life even during periods where they may be apparently "better".</p> <p>9) I think that you would have to try really hard to make it more difficult! When I filled in the form for my daughter it was always a really difficult experience. As soon as the pack</p>

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	<p>landed with an enormous thud on the doormat my heart sank! I used to put it away for at least two weeks before I plucked up the courage to start filling it in. I was frequently reduce to tears by the whole process of having to say how far she could walk and listing things she couldnt do. If you plan to make people fill in the form at regular intervals it would be really helpful if you could send a copy of the previous claim so you could just make any changes. The form was so large that taking a photocopy wasnt really practical (even for those whose employers didnt mind you using their machine and paper - I shudder to think how much it would cost if you had to use a machine where you had to pay for each page!) If you are going to have an on-line system then it should automatically pull up previously submitted data.</p> <p>The information about the benefit should be clear and unambiguous, particularly about the criteria used and the length of time the benefit is awarded for. For example up until my daughter was 16 I had to re-apply every 3 years. I spoke to a colleague who had a son with autism(who was 3 years younger than my daughter) during this time and she told me that he had been awarded the benefit until he was 16. I was somewhat confused by this and phoned the DLA helpline asking what criteria there were for decisions about the length of time an award was made for and was told that it was the individual making the decisions call. This is not good enough!</p> <p>I also found it very difficult when at age 16 a person was sent to my house to interview her to see if they could continue to pay the DLA to me as her representative. I found this process offensive and unnecessary.</p> <p>10) This will depend entirely on the individuals circumstances and which professionals are involved. Some people may only have contact with one or two professionals whereas others may have regular contact with many more. In my daughters case the major barrier to her living an independent life is her learning difficulty but her restricted vision also has a significant, additional impact on her daily life. In her case I would expect you to need supporting evidence from someone who knows the impact of her learning difficulties and someone else who understands the impact of her restricted vision.</p> <p>11) Many people will see this as the government trying to avoid making payments to disabled people. Where are you going to find all of these trained and experienced healthcare professionals? Surely you are trying to assess the IMPACT of an illness or disability on a persons daily life. How is a short interview going to accomplish this? As I have already said in my answer to previous questions, an unsupported interview of this type would be a waste of time.</p> <p>12) Whatever the system for carrying out reviews they should be transparent. Each individual should be told, when first receiving the benefit, about the frequency of reviews. The first review could be a very simple one asking the person to confirm any changes and with some supporting evidence from a professional who knows the person well. I there have been changes then a more detailed review with more evidence would be triggered. You should always send a copy of the information you have to make it easier for the claimant. It should be clear that there is a responsibility to notify any changes between reviews - you could always do random interim reviews where a person has a condition which is more likely to change</p> <p>13) See response to question 12</p> <p>14) Good quality information is always necessary. The form and any guidance should be as clear as possible. I have always found that DWP staff are very helpful</p>
ONLINE130	<p>1) In my experience transport issues are the single biggest hurdle to leading an independent active life. The simple act of getting from A to B has been my biggest challenge. Using public transport has always presented challenges that can sometimes be overcome but travelling in London on public transport during is a challenge that is often hard to overcome, whether or not you are a wheelchair user. A lot of aids are relatively cheap to acquire in my experience sock-pullers and the like. I have no experience of the cost of major adaptations for wheelchair users so I cannot comment directly on this.</p> <p>I have been fortunate that I have been able to work for all of my adult life, my DLA payments in recent years have helped me travel independently and not rely on public transport, as even though I am not in a wheelchair I find I cannot use especially during rush hour.</p>
ONLINE131	<p>1) being disabled strips you of your dreams and aspirations. Also your whole thought process becomes changed and access o areas can be difficult</p>

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	<p>and you can be prevented because of your illness as you preparing for the future depends on how you are feeling that day it can become overwhelming.</p> <p>2) Status Quo</p> <p>4) no illness fluctuates</p> <p>5) AUTOMATIC ENTITLEMENT eg wheelchair aided,mobility,personal care one of which should be multiple Sclerosis</p> <p>6) Mobility and access to personal care. normal activities become an essential part of your life</p> <p>7) Listen to the medical Practitioners who are dealing with the disability</p> <p>8) no as any will be seen as possible reduction in their help</p> <p>9) A response from your consultant should suffice as the ones assessing are target driven</p> <p>10) As response submitted in Question 9</p> <p>11) Your Health professional will be target driven employed to drive down cost whether at home or office</p> <p>12) medical profession of those who are treating the illness eg Multiple Sclerosis NO CURE NO HOPE</p> <p>13) Multiple Sclerosis no change only progression medical evidence will back this up</p> <p>? ) Letter to remind and if no response take it as read no change.</p> <p>There is distrust from the Government for those who are medically proven disabled</p> <p>? ) Listen to the groups who represent the Disabled instead of blatantly trying to hammer the vulnerable of society who are trying to live a normal life which others like yourselves see as an easy target too rectify the bankers mess and colleagues of yours who misled the public and filled their own pockets</p> <p>? ) Medical Assessments from the practitioner who is dealing with the patient</p> <p>? ) No the individual is well prepared for the advice given as How can YOU GIVE ADVICE ON AN ILLNESS YOU DON'T LIVE WITH.</p> <p>? ) The parents or carers</p> <p>? ) To remove themselves from society thus becoming isolated and becoming more dependent on the state for help.</p> <p>? ) via THE dla benefit which is what it is designed for</p> <p>? ) Yes dental treatment and to those are able to work due to the DLA benefit give them a Tax breaks as through adversity they are still contributing to society and trying to live a normal life and refuse to become state dependent.</p> <p>? ) Yes thanks for consulting remember a consultation is to listen</p>
ONLINE132	<p>1) The way that other people treat you if you are on a disability scooter, they treat you as if, even if it is your legs etc don't work properly anymore, your brain has also gone, which is very annoying</p> <p>2) I think that the DLA should stay the same, as it works very well now</p> <p>4) There should be 3 levels of support, because otherwise there will be people missed out, as it is hard to get it now, with 3 levels, so it will be worse, with just 2 levels</p> <p>6) I think being to go out and get on a bus, as it is impossible for me at the moment, as I cannot walk far enough to get to a bus stop.</p> <p>8) The assessment should only take account of the aids and adaptations that they have already, as the disabled person knows just what will help them, and make them feel like an individual</p> <p>10) How can a healthcare professional, know just how it is for a disabled person, because they haven't been in their shoes, and haven't learned to live the disability, like the disabled person</p> <p>12) There should no reviews, because the disabled people have enough to live with, without having to keep having reviews, it would be very upsetting</p> <p>13) The thing is, that you keep having to adapt to the extra pain etc and just don't realise how much worse it is, than it was</p> <p>14) I don't think you realise that quite often, a disabled person, doesn't realise just how bad she has got, only the person who looks after them all the while, realises, whether it is a carer or husband</p> <p>16) The majority fund the help for funding their aids, themselves, by buying themselves a wheelchair or mobility scooter, as it is great to have a car provided through the fund, but what is the point of having a car, without having something to use, when they get out of the car, otherwise they are sitting like a lemon, because they cannot go anywhere without their aids</p>

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	<p>?) I haven't found that haven't the DLA has helped me get any other benefits or services, as it isn't means tested, they always presume that with the DLA we can now afford every thing ourselves, which is ridiculous, because we are already having to buy other things to help us</p>
ONLINE133	<p>1) Prejudice and ignorance are a significant factor - there needs to be more public awareness about the positive lives that people with a disability can lead. Fear - of people with mental health problems Disability is expensive to be able to participate fully a disabled person needs to be on equal financial terms with non disabled people.</p> <p>2) Higher rate mobility component should remain 2 rates of care component should remain There should be sufficient measures in place to ensure that the benefit is targeted only to those in genuine need</p> <p>3) Specialist equipment / aids Extra travelling costs for medical reasons - taxi's etc Help at home for domestic tasks / cooking</p> <p>4) The significant change would appear to be abolishing lowest rate care for main meals / attention for significant portion of the day. This will cut costs but will not necessarily have a big impact on administering the benefit. There is a risk that vulnerable people eg those with learning difficulties who need help with daily living such as cooking a main meal but do not need help with personal care per se will be disadvantaged by this change and will fall out of the scope of PIP</p> <p>5) Extend the deeming provisions for : DLA to cancer patients undergoing chemotherapy for a fixed period. Cancer patients face huge costs when undergoing chemotherapy and face losing their jobs.</p> <p>6) DLA already considers activities related to an individual's ability to get around, whether they need guidance or supervision outdoor interact with others, (difficulty with communication) manage personal care and treatment needs, and access food and drink. (plan and prepare a cooked main meal). These are all essential activities which should be taken into account when determining entitlement to PIP.</p> <p>7) For people with serious mental health conditions such as schizophrenia or manic depressive psychosis greater emphasis should be placed on medical guidance and reports provided by healthcare professionals or Social workers who know the customer best. A single ATOS consultation is unlikely to provide a true picture of the customer's needs. For physical conditions which "flare -up" it is important that decision maker obtains sufficient evidence from HCP's to be able to establish frequency / duration of illness.</p> <p>8) I am strongly against considering ability to get around in a wheelchair because I do not consider this is a substitute for walking. A wheelchair user is not walking, unlike someone who may be able to walk with a prosthetic leg. It is important to consider aids and adaptations that a customer may reasonably expect to use or purchase such as a walking stick or frame, chair risers etc but unless there is evidence that the local authority has or intends to install larger items (such as showers, raised toilets, ramps etc) then it should not be assumed that the customer has access to them.</p> <p>9) Produce a shortened version of the claim form whereby the customer states his identity details and his disability but does not need to tell us how this affects him. Decision makers to gather evidence by phone or refer for home visit. Customers will feel they are having an individual service. However this will be more expensive and time consuming for staff. TV and other media advertising will raise awareness about eligibility for PIP</p> <p>10) The customer or person that cares for them Their GP / CPN or consultant A PIP visiting officer Independent HPC</p> <p>11) For customers whose eligibility is in doubt (for example you would not expect the condition to be as disabling as described) face to face discussion is likely to resolve any questions the decision maker may have.</p> <p>13) Make it clear that there will be penalties if we are not kept informed of changes Send a prompt or reminder at intervals during the life of the claim</p> <p>14) Signposting to Social Services / Local authorities / charities at the initial claim stage</p>

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	<p>would be useful</p> <p>15) No comment</p> <p>16) Major aids and adaptations are generally funded by Local authority. Customers should be given the independence to make their own decisions where possible regarding the purchase of aids/ adaptations.</p> <p>17) There has recently been a great deal of work around payment of DLA for children, with new guidance for decision makers which could be used as the benchmark for assessing children for PIP. Child claims should be within the scope of PIP but with some different criteria</p> <p>?) None</p> <p>?) No comment</p> <p>?) It would be a retrograde step and undermining to the aspirations of "joined up government"</p> <p>?) All HCP reports should be shared</p> <p>All information about residential care funding</p> <p>All social services assessments when there is a PIP interest</p>
ONLINE134	<p>1) people with conditions which do not meet the criteria for DLA or the higher rate often miss out on passported benefits ie bus passes, blue badges,. They then finish up quite isolated and find it difficult to participate in everyday life</p> <p>2) information about support services depending on condition, services of DEA in jobcentres. Many people applying for dla/pip dont know or have never used the jobcentre and are not aware of the services of DEA, a new medical condition that means they are applying for pip may mean they are in danger of losing their job, DEA services/retention could be appropriate. With new health conditions customers often feel frightened and anxious so additional support at this time is critical.</p> <p>3) transportation costs are often significantly higher for disabled people especially where public transport is limited. In these circumstances customers are having to use taxis or pay other people to help them with everyday things like shopping, doctors, dentists and other medical appointments. Where specialist equipment is required this again can incur extra costs as all equipment is not provided by social services or nhs. Eg stair lifts, toilet/bathroom adaptations. Disabled facilities grants are means tested and quite complex and often people are put off by the application process.</p> <p>4) There may be a problem where current lower rate doesn't meet the criteria for the new lower rate therefore precluding more people from entitlement.</p> <p>5) claims should always be based on the individual as every person deals with an illness uniquely and copes with pain differently. There may also be other underlying health conditions that affect the way they cope ie depression/mental illnesses. eg a person with impaired sight may not find this prevents them from doing everyday tasks, but a person with impaired sight and mental health issues may find everyday life unbearable, going out very difficult but cause of the added effects of anxiety/depression.</p> <p>6) Every person needs an initial face to face contact to assess the effects their health and disability has on their life. A fundamental human right is the expectation that wherever possible people can get out of bed, move about and participate in the world outside.</p> <p>7) DLA needs a more frequent review process, progressive recurring conditions can change very quickly. There needs to be a mechanism by which changes can be declared and reassessed in a simpler way.</p> <p>8) a fit all medical/work capability assessment for DLa, ESA, gp's and for occupational in work services, the person doesn't change, the condition remains the same. There are instances where a customer goes for a medical for dla and wca for esa in same week with same person. How wasteful is that</p> <p>9) Initial claim should be a face to face initial assessment, less duplication of the questions, customers find it easier to be honest and admit to their difficulties in a discussion than in writing. Customers often sell themselves short because they don't always consider their varying needs and what they can't do when answering questions on a form. There also needs to be an easy to read fact sheet, which should be available in libraries, doctors surgeries, cab welfare rights etc.</p> <p>10) REPORTS FROM GP'S, OCCUPATIONAL THERAPISTS, PHYSICIANS, PHYSIO'S, THERAPISTS AND OTHER HEALTH PROFESSIONALS</p> <p>11) see question 9</p> <p>12) medical supporting evidence, feedback from customer of a considerable change in condition both deterioration or improvement.</p>

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	<p>there should also be shorter reviews not requiring total reassessment depending on health condition. Closer links between the nhs services and DLA.</p> <p>?) parents fill in for children perceptions and difficulties can be very different viewed through the eyes of a child, children are not independant and children with additional needs attract extra travel costs for parents with fetching and carrying. Behaviour/emotional difficulties have a significant effect on the level of parenting required with children, especially the extra support needed in school, extra involvement the parent has to have with a child and the additional costs this incurs for parents around school visits/meetings, loss of earnings at work for time off for assessments, camhs appointments, doctors appointments, visits to school to sort out difficulties</p> <p>?) through social services/grants/personal savings/income, benevolent organisations, ie ex fireman/policeman etc.</p> <p>The option to use pip to fund adapatations would add another route into help, many customers don't have access to credit at reasonable rates and often find themselves in the hands of loan sharks and end up in lasting, unending debt especially the most vulnerable.</p> <p>?) Regular reviews using telephone contact to report changes, media campaigns, leaflet drops in national newspapers, links to other organisations, useful numbers easy to read information, story boards, road shows, media/advertising awareness campaigns.</p>
ONLINE135	<p>1) 1)Prejudice by certain members of the community because disabled people may look, sound, and understand things differently to the rest of the population.</p> <p>2) Fear from generally decent population that if they interact with someone who is disabled, that the person will not respond in a "normal" way and therefore an awkwardness may arise meaning that most people would rather not try and interact in the first place.."just in case"</p> <p>3)Fighting. Having to fill out this form for my daughter, having to do the DLA form for my daughter, having to take her to 7 medical apporintments some weeks, having to fight for hew swine flu Jab in case her probable heart condition arises, but it isn't there at the moment, so she's officially not entitled. If I die,(which without wanting to be morbid, is the usual chronological chain of events) Who will do this for her?</p> <p>Equally the thought of her having a medical appointment with a professional who doesn't understand her rare syndrome "██████████ Syndrome" puts the fear of God into me (educated to degree level and have worked as a buyer for 10 years ie I'm quite a tough cookie really) I resent having to justify her and sit in an appointment telling yet another professional about what her syndrome is again and again and again, this really upsets me and it hinders her because it's just more beurocracy and yet more red tape. She has a team of independant professionals that surround her who constantly write reports about her, why can these not be used to save her and me jumping through more hoops and red tape?</p> <p>2) I am glad that DLA is not means tested. The company I work for have allowed me to work from home so that I can take ██████████ to all her appointments, it also allowed me the freedom to move back up North so that we could live in a larger cheaper house. So in one sense I'm really lucky because I can carry on working, the counter balance to this is that I had a high flying career in London. I had paid to go to university, I should have been earning a good 20K more than I am by now and would have been had I not had a child with a disability. I am stuck working for the company I am with, with no defined career path now. So yes lucky in one sense that I can work, but actually it's completely changed and altered our lives. The fact that we get this money and it isn't means tested, has given us a bit of freedom. le we can take her out for days out. It's helped when we've had to buy new washing machines (she soils herself up to 5 times a day) new clothes (same reason) New car seats (same reason) a car, so that I can get her to places easily without her running off with strangers (a condition of her syndrome).. I was happy living in London before, and I was happy without all of these things, but we have needed to get them because of her disability. Of course we would pay for them ourselves, but I for one am happy to live in a society where we look out for the weak and vulnerable, and had ██████████ been a healthy child, would have been happy for some of my taxes to have been spent supporting a family who had a child with a disability, even if they were working. I'm not sure the general population would agree with this at the moment, but I think it's the right thing to do. Similar to government policy in keeping a charity fund to help poor countries for disasters. It's the right and proper thing to do.</p> <p>By the way the counter balance to this is that the DLA form is absoltely awful. It takes me days to fill out and I cry and grieve for the child I'd originally hoped to have all over again every time I'm forced to re fill it out. It's just a constant reminder of how disabled she is</p>

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	<p>rather than a positive statement about what she can do. I didn't know how disabled she was until I first filled that form out. I cried for days. (as i said in an earlier answer I'm quite tough normally)</p> <p>3) That's a really difficult and not very well thought through question is it? Disabled people are as different to each other as "normal people" aren't they and so therefore the question is quite poor.</p> <p>In the specific case of my daughter. Which is surely the only answer I can give without being patronising to other people.. She needs, nappies, pants, new clothes, new car seats, new washing machine, a car so that I can get her around without having her talk to everyone and go with strangers eg if I were just going to the Supermarket. Without the car it would take hours just to chat to everyone en route.</p> <p>I have had to move her bedroom, so that she is away from the new baby and will be less likely to become stressed and anxious in the night (she suffers as part of her [REDACTED] syndrome from acute hyperacusis which means she has extremely sensitive hearing and becomes especially anxious near noises with emotion or a perception of emotion attached to them. I have to leave lights on in the house at night, and have to use the washing machine up to 5 times a day (ie increased electricity)</p> <p>She can't just go round to a friends house to play like other children do, she could easily fall downstairs or wet herself.. so we have to take her on days out, so that she can have some quality of life.</p> <p>A further expense in a sense is our loss of earnings rather than just the specific cost of direct help for [REDACTED]. As said in a previous answer, had [REDACTED] not been disabled, I would have still been living in London, would have made far more money on our property, would have been on a far higher salary etc, as would my husband.</p> <p>4) I think this is fine in principle. Any simplification of the process is welcomed.</p> <p>5) Yes Please!!! This would make all our lives so much easier and cut out so much red tape. If there was a general consensus that for a child with [REDACTED] syndrome or Downs syndrome or whichever disability.. that they have a certain level of disability and entitlement then this would help so much. People could claim for more if there child was extremely disabled, but I for one would rather have a bit less and not have to constantly justify my child. Honestly. I get so fed up with people making judgments that she is a "stuck in front of the TV wishy washy syndrome made up for benefits child" when in actuality she was born missing 28 bits of DNA along the long arm of Chromosome 7. It's a proper medical and clearly diagnosed condition. Sorry if that's not helpful to other people who genuinely have disabled kids without diagnosis, but I think it would save a huge amount of my time as a parent and government time if the ones that did have a specific professionally diagnosed condition had a specific level of benefit. This could then be added to where there additional or severe problems over and above..most people probably wouldn't go through all the red tape to try and prove there were additional problems especially if criteria were strict. You could save money this way.</p> <p>6) Going to the toilet, Going to the shops, Being able to make a cup of tea, being able to cook, get dressed, wash yourself, interact with others. Being able to use a phone, being able to be left alone, being able to cross the road safely, Understanding the world around you and being safe within it.</p> <p>7) Have specific conditions with a specific level of benefit attached and allow to apply for extra money if their condition is worse than the general criteria for that condition allows. For fluctuatiog conditions.. have a 3 month grace period?</p> <p>8) yes any aid which "normal" bodied people don't need to do the same tasks..</p> <p>9) It might have been easier, quicker and cheaper in the long run to actually sit with a professional and write the form out.. ? If it said "If your condition is eg "[REDACTED] syndrome " go to question 29. ie you know all the answers to the interim questions, so it's just a case of checking any other bits.. that way you save huge amounts of time for us as parents and you in financing the process and also filter out people who are making a mockery of the process.</p> <p>10) Statement of Special Needs, Medical assesments, physio reports, Occupational Therapy reports, Seech therapy reports, paediatrician reports etc etc.. The reports these people already do eg for a statement of special needs should be enough to be used here too. I can't comment about adults, but it would seem madness to have these professionals have to duplicate work when they have already written reports which clearly detail, in the case of my daughter, her disabilities.</p> <p>11) In the case of my daughter it's really tricky. Her syndrome is so rare that her</p>

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	<p>paediatrician has never come across it in 30 years of practice. That said it's very real, it's genetic and she's missing DNA.</p> <p>She presents beautifully though, her language is lovely, it's the understanding that's behind it that is the issue in this instance. She's in the "retarded" bit of IQ level. (for want of a far nicer word) but at first glance she almost presents as gifted because her language is so good. I worry that a healthcare prof who doesn't know [REDACTED], or doesn't know [REDACTED] syndrome will totally misinterpret her based on a half hour appointment. I am fed up of having to justify her disabled status. It has a profound effect on our lives and is very real. The answer here would be to ensure that any healthcare professional judging her eligibility to a financial benefit be someone who is aware of the syndrome or illness of the person involved. Or have a healthcare professional who already treats her ie her paediatrician. How you manage this I don't know, but I feel it essential to make the process fair.</p> <p>The benefit of a specific appointment would clearly be that we would not need to spend days filling out the heartbreaking DLA form.</p> <p>12) If the person has a specific syndrome or recognised disability or a long term disability with a known set or needs and requirements the re assesment surely needs to be less frequent.</p> <p>If someone has the potential to improve or get better it needs to be more frequent. I'd hate to suggest how often as I don't feel eligible to do so, but you'd need to work this out based on your evidence and advice. Clearly at some point you're trying to save money and give to the most needy. I'm not sure how often you'd need to reasses, but the actual money bit ie the government's spending will probably have a big influence here.</p> <p>13) That's going to be really difficult. Without appearing to be Nazi police, how are you going to monitor it and ensure people don't take advantage..? well one way I suppose would be as in the above answers I gave, so for recognised conditions there is a set level (with extras for special or additional circumstances)</p> <p>For the others people could be more frequently assessed by their own healthcare professionals, ie "no specific change" and therefore you get to keep on top of it. If you have loads of "police" hiding behind hedgerows it's clearly going to be pretty awful for the majority of claimants who are bone fide.</p> <p>? 1) that they are different to their peers.</p> <p>2) that they may improve if it's not a recognised condition.</p> <p>3) The impact on family life, and the way having a disabled child effects the whole family. IE to means test parents would be grossly unfair.</p> <p>? Anything that simplifies the process so that legitiamte people can claim, and filters out non legitimate people has to be a good thing.</p> <p>? As said earlier medical reports and assesments could be used again and again especially if a child has already been assessed by many professionals for a statement of special educaional needs.</p> <p>? Make sure you do adequate advertising / marketing at hospitals etc so that all ethnicities and backgrounds can understand / claim.</p> <p>? [REDACTED] got a blue badge in part because the DLA gave a validity to our claim.. that's all I can comment on that really.</p> <p>? Occupational therapy supplied [REDACTED] toilet frames and the school paid for her special chair, if PIP wanted to give us a one off payment to fund these then that would be fine, but I worry that less scrupulous or responisble parents may abuse this system and spend the money on other things, ultimatley in this instance the child would miss out.</p> <p>? Yes I'm sure it would if they are disabled and adult, especially if their needs are mental rather than physical. That;s my fear for [REDACTED], ie when [REDACTED] and I are gone who will look out for her. If there was some system that would provide help to ensure she can claim fairly then it would put our minds at rest.</p> <p>? Yes, I wasn't even aware of DLA until [REDACTED] was 2 1/2 we missed out on a lot of benefit for her. It would be helpful if when she's an adult someone prompt her or take the initiative to claim for her because from what I can gather she is unlikely to do this for herself.</p>
ONLINE136	<p>1) I have a daughter with severe disabilities (learning and physical) living in care and I have rheumatoid and osteo-arthritis myself, causing me mobility problems although I still work.Part of the reason for the osteo arthritis is that I carried my daughter for the first seven years of her life as she lived with me until she was 19. For my daughter, society's view of her prevents her from participating fully in society plus access due to her mobility problems. She is in a wheelchair and access continues to be a problem. Out of her allowance, after her contribution to her care, she is left with £22 per week. This is not</p>

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	<p>enough to access the community fully and certainly does not pay for her clothes or personal items, such as towels, bedding which I pay for. She is heavy on clothes and she costs me about £5000 per annum. I am retiring this year and am concerned about how I am going to afford to pay for her. Also, I need a car in which I can easily put her wheelchair, bearing in mind my own problems too in order to take her out. As for myself, my RA means that I have problems again with access because I have problems with stairs or steps. Transport can cause me a problem because of steps, walking and the fact that getting up from a sitting position takes me a while before I can move (this makes trains, taxis, coaches, underground all really difficult to cope with). Society is still not very disabled-friendly.</p>
<p>ONLINE137</p>	<p>1) My son's problem is that he needs to have a carer with him at all time to offer support for communication, appropriate behaviour, understanding health and safety risks and to actually carry out tasks. He requires ongoing prompts all of the time and cannot carry out every day activities independently. With support from another person, he can lead an active life.</p> <p>2) There must be retained an acceptance that supervision with tasks is a recognised need.</p> <p>3) For my son, the costs associated with always paying for a second person to go to a place where without a disability he could go himself.</p> <p>Also the costs of continence products which the health service refuse to provide; transport to school costs which the local education authority insist we pay as his nearest school was unsuitable.</p> <p>4) It may be a too broad brush and not be individual enough and acknowledge people who have a real but lesser need.</p> <p>5) Individual circumstances</p> <p>6) Having support and funds to wash dress, eat, drink, manage medical conditions including anxiety and mental health problems, communicate, mobilise and participate in activities outside the home.</p> <p>7) Ask people to describe a good day in the last two months and then a bad day for each question. Those DLA questions about how many days it effects you were ineffective.</p> <p>8) yes</p> <p>10) Supporting letters from health and social services professionals and services used by the person.</p> <p>11) A carer must be allowed to participate in this assessment, particularly for people with mental health problems and learning disabilities or with other problems which effect communication. Some people with behavioural difficulties may need an exemption and evidence for this could be sought from involved professionals.</p> <p>12) For people with lifelong disabilities effecting them from birth, it is both stressful for carers and pointless to review them regularly. They should be reviewed at longer intervals (and perhaps on a shorter form!) with back up evidence from professionals. People with curable conditions should be reviewed more regularly and in more depth.</p> <p>13) With the annual statement of benefit, add a form to fill in and return to state any changes and trigger a review.</p> <p>?) Although it does not effect my son, I am deeply concerned, (through my work in social care) about the probably relatively small amount of people, particularly young people who are well placed in residential care but who rely on mobility allowance for all their quality of life. These people will be extremely disadvantaged by the proposals through no fault of their own and irrespective of their level of disability or their ability to access the community with appropriate transport and carer support.</p> <p>?) Information on accessing local social care may be useful although GPs should be providing this.</p> <p>?) That any effect on life is compared to another child of the same age.</p> <p>?) There would be multiple assessments and this would waste time and funds in other areas.</p>
<p>ONLINE138</p>	<p>1) Although there are many aids available to assist disabled people to be more independent, most of these require the assistance of an able bodied person to set up and then switch off \ dismantle after use. Some aids require the constant assistance of a carer particularly when outside e.g I use a chin controlled wheelchair which enables me to move semi independently but require assistance in opening doors, using lifts, paying for shopping etc. Despite the DDA and more recent Equality Act many public places remain inaccessible to wheelchair users, particularly power chair users. Uneven pavements,</p>

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	<p>narrow doorway and steps where there is no alternative means of access are every day barriers to be faced just to get inside a building . Then the next battle is to get the receptionist \ shop assistant to a) speak to me and not my carer and b) not to treat me as an idiot etc.</p> <p>2) Claimants should continue to be able to use the new benefit in the same way that the DLA can be spent; on items or services that each person needs to live a fuller and more active life. The proposal that some or all of a person's PIP should be used to fund vital equipment, which is currently supplied free of charge, would remove the ability to exercise choice and give rise to further hardship for disabled people. I rely on my DLA to enable me to own a wheelchair adapted vehicle and pay the extra living costs incurred due to needing a live-in carer. If all or part of my PIP had to be used to fund the numerous pieces of equipment I use in addition to being unable to pay my utility and food bills I wouldn't be able to afford to run my car. I would be house bound. Thus denied the ability to take an active part in my local community.</p> <p>3) As a single person who due to the severity of my disability requires a live-in carer I incur the following additional costs:</p> <p>a. I have to live in two bedroom accommodation which cost more to buy than a one bedroom properly. my ongoing property costs are also higher; more expensive property equals higher Council Tax banding and larger property means higher heating bills. Note I do not qualify for council tax benefit or the winter fuel allowance.</p> <p>b. I have to pay for the additional food, water, electricity and gas consumed by this second person living in my home.</p> <p>c. As I am wheelchair bound I am unable to generate my own body heat and need to have the central heating on a high setting all day to keep warm.</p> <p>d. All of the equipment I use is either battery operated which needs daily recharging or uses mains electricity.</p> <p>e. As the registered keeper of my wheelchair adapted vehicle but not able to drive myself I require specialist motor insurance to cover anyone over 25 to drive my car. This has increased my annual premium by approximately 30%</p> <p>4) Reducing the number of rates per component will narrow the current flexibility built in to the DLA. Removing the ability to take account of the variable needs of an individual's care and mobility requirements is a retrograde step and contradicts one of the key objectives of the proposed reforms. Shoehorning claimants in to two rates will not give each person access to funds tailored to their individual needs.</p> <p>5) In order to reduce unnecessary administrative costs, where entitlement is obvious, certain health conditions or impairments should automatically be eligible.</p> <p>8) This is a very difficult area to manage fairly. While I agree that reform is needed here there is a grave danger that decisions regarding entitlement to benefit could be made arbitrarily and not take in to account each individual's needs. For example one person using a wheelchair could be as independent as an able bodied person, another wheelchair user could be highly dependent on the assistance of a carer. Assuming that simply supplying a wheelchair would remove entitlement to benefit is therefore too simplistic.</p> <p>9) At the start of the questions make it clear that responses should be made based on the least that can be done and not what they can do with effort on a good day. Get the claimant to map out how daily tasks are carried out by asking how they do each step, le get out of bed, wash, dress, prepare and eat breakfast etc asking how they do this, with or without assistance or some assistance? At the start of each section explain what the next set of questions are assessing. If using tick boxes always have one that can be selected when none of the listed responses apply with space to write their own answer. Have the form available to fill in online.</p>
ONLINE139	<p>1) Barriers to society are not only physical but also attitudinal. Information is only provided in accessible formats on request, not as standard. Not having full access to high quality information puts up barriers to every other aspect of life. Additionally funding for social care is woefully inadequate resulting in underinvestment in care services and rationing of assistance from social services. More and more people are being refused financial assistance for care services or are having packages cut with charges being increased at the same time. Packages are more and more likeley to consist of the bare minimum feeding, watering, toileting and dressing services - leaving people ever more socially isolated and less likely to be able to participate in any meaningful way in the community / work market. Additionally there has been ever more negative press concerning benefit</p>

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	<p>fraud (particularly DLA for some reason) with innocent people labelled as scroungers even though they are just claiming what is rightfully theirs to claim - this has led to disabled people being viewed in a poor light which in turn has led to a confidence crisis not only by the disabled person themselves, but also by potential employers or even potential partners. Unfortunately with the sweeping cuts that this government is bringing in this just adds to the devaluing of disabled people.</p> <p>Financially disabled people are one of the poorest sectors of society not only because we are devalued but also because of the additional expenses we have when it comes to extortionately priced specialist equipment and the fact that many of us have to essentially pay to be able to get up, get washed etc (in terms of care charges) whereas non disabled people do this by themselves (for free!)</p> <p>Parking €“ not enough spaces, restrictions on all day parking (when working)</p> <p>Pedestrianisation and no transport around that area</p> <p>Cost of running a car</p> <p>Buildings not adapted</p> <p>My own energy levels, muscle weakness, and fatigue</p> <p>3) Running a car</p> <p>For me:</p> <p>Petrol for many short car journeys</p> <p>Pay for car to be cleaned and maintained, as I cannot do it</p> <p>Pay for garden to be maintained, as I cannot do it</p> <p>Pay for easy cook food, as I cannot cook meals from scratch</p> <p>Delivery costs for online food and other goods shopping, as it is hard for me to walk round shops</p> <p>Harder to find bargains, as can't walk round to source them</p> <p>House maintenance and repair, decorating</p> <p>4) Having two rates is better, as the flexibility will ensure that fewer people who need the support miss out.</p> <p>9) Clear, readily available, guidelines are essential</p> <p>10) My own GP's and consultant's evidence is important, because my disability is largely invisible.</p> <p>11) It will be very difficult for a face-to-face interviewer to accurately assess my largely invisible disability, as a large component is fatigue, which is cumulative throughout the day. I also suffer from muscle weakness, which is not easy to assess.</p> <p>On the plus side, it might be an opportunity to explain in more detail the difficulties that I face.</p> <p>It is important that there is no hidden agenda, or trip words that trigger an automatic rejection (like the buzzer on QI).</p> <p>?) I use mine to pay for my car, in large part. I value the flexibility to use it for whatever I need most at the time. I also use it to pay for someone to maintain my garden, for extra costs incurred with everyday shopping.</p> <p>?) It is vital to maintain the passporting to the Blue Badge Scheme.</p> <p>?) Extra work for disabled people, filling in more forms.</p> <p>Delays for disabled people.</p> <p>Extra admin for staff administering the Blue Badge Scheme.</p>
ONLINE140	<p>1) These are clever, carefully thought out words and phrases: however the reality is that many seriously disabled people will suffer unnecessary uncertainty and cuts.</p> <p>2) There is a clear distinction between people who are "temporarily" disabled and those - severely sight disabled (blind) for instance - who should obviously qualify for DLA. Why does this latter group have to go through a pointless review system unless the underlying purpose of the reforms is do damage people? It would be simple to maintain certain categories of existing claimants on the present system.</p> <p>4) The only real advantage is its purpose - cost saving at the expense of the disabled.</p> <p>5) Yes. It is a pointless administrative exercise to have the obviously long-term disabled make individual cases.</p> <p>8) No. You would in effect be penalising people for trying to improve their lot.</p>
ONLINE141	<p>1) Work is a problem as the disability will limit the work to part time which has an impact on their income and therefore resources for extra help they need. Also disabled people tend to have more sickness especially with their condition which leads to them losing their</p>

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	<p>jobs even when they perform their jobs to standard when they are well and in work. This means to not push the disabled person over their limits of work they have to work less hours and therefore need help in making up their money to help them pay for the extra help they need.</p> <p>3) Paying people to do household duties such as cleaning and ironing. Also for extra aides such as stair lifts. Mobility is a big issue and I am unable to get around even to the DRs without a car. Also the blue badge means that I can get closer to a location meaning less distance to walk and therefore less pain.</p> <p>I also currently work part time and the extra money has enabled me to remain in work by reducing my hours and days worked. My alternative was ill health retirement from the civil service. I have however had to reduce my hours many times as my condition has worsened to enable me to remain in work.</p> <p>5) Some conditions have peaks and troughs and the person can go through good spells M.S. being one. For this reason I think all claims should be assessed individually.</p> <p>6) It has to be left to the individual. What might be a full and active life to one person is different to another. Some people with disabilities are not able to take part in some activities and making the home more comfortable and secure financially is more beneficial.</p> <p>7) GP's are best placed as they see the individual regularly and are aware of how their condition affects them .</p> <p>8) I don't think aides should be used. If you have tried using an aide you would see that they may help the individual but that also comes at a cost. This could be pain caused by using the aide such as a prosthetic or walking stick. I get extreme pain and when my hands are bad I am unable to use my stick as it is too painful. Using a wheel chair is also the same. I think that you should try using aides and see what impact it has on your daily life. It may help you get about but it is not without other problems.</p> <p>9) making the form shorter and more concise.</p> <p>10) The GP sees the person the most and has better understanding of the person's disabilities and home life. Some disabled people don't like to think of themselves as disabled .</p> <p>11) For people with mobility issues the centre should be easy to access with parking outside.</p> <p>The health care professional should be up to date with the latest medical findings of the condition.</p> <p>If the discussion is likely to distress the customer it should be conducted at their home.</p> <p>12) The new benefit should be reviewed at least 7 yearly as different medicines etc are now constantly being discovered that help all sorts of conditions.</p> <p>?) Any other benefits claimed where a medical was completed or medical report was obtained should be used across the board.</p> <p>?) For people who manage to work there is no other funding to tap into and some adaptations such as stair lifts, chairs, beds are expensive and require a loan to buy. An interest free loan repaid direct from the benefit may help.</p> <p>?) If a GP or health professional has stated the customer should try a certain aide to help them be it a therapy or a group and they refuse the award should come with a suggestion that they should try this and that it would "not currently affect their award". Some people are scared to become well in case the financial support then ends. This is a big barrier for Disabled people.</p> <p>?) If you are now looking at people's ability to have a full and active life the age will also have an impact. If comparing to a young person they are more likely to be more active if well, therefore if disabled the impact could be greater than that of an older disabled person as older people generally aren't as active.</p> <p>?) It would involve the customer going through a longer period of having more medicals and waiting longer for benefits and services.</p> <p>?) The mobility and BlueBadge scheme is a key factor for people with mobility issues. There is however a huge amount of fraud with other people using badges especially in car parks and supermarkets.</p> <p>?) This has to be fair to disabled people and look at all aspects of their life. As stated when looking at children they are compared to what a child of that age does why does this not affect other ages. Over 65's for instance are not as active and therefore any aspect of their daily life should be compared with that of a normal person of that age. For a younger disabled person not being able to live a full life has a greater affect seeing friends doing so much more.</p>

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	<p>GP's should have a greater role as they have a relationship with the patient over long periods of time .            People making the decisions should have a full impartial knowledge of the disability. Some disabilities are relatively newer such as ME and Fibromyalgia and yet have huge impacts on a persons life.</p>
<p>ONLINE142</p>	<p>1) I do not have the benefit myself, but reading this and seeing various people there isnt any barriers really, the person who has the disability knows what they can and can not do, it doesn't need the governement to tell them what they can and can not do.            2) Everything should stay the same has it is now. By reading your answers the question is WHY CHANGE!!! it just seems so stupid and a waste of money in change a name, the name change means new letter head and a cost and the web site name change again a cost WHY !!.            As go for people who are 65 years old, these people are clearly not working age, so why review them, by doing this do you know how much stress and upset this can cause in fact in someone at this age and above could cause death because of all the stress and upset, the benefit should clearly not be review for anyone over the age of 65 Years Old it should be clearly just paid out just like it is now. By looking at the graphs in the previous pages it showed a large rise in the working age people from 16 years, this should tell you that these people aged from 16 to 60 years old, clearly do not want to work and this stand out so you should be looking at this age and leave over 65 year old, ( I am the age of 40 years old, and there is alot of people out there my age who do not want to work.            3) I would have thought the main extra costs that disabled people face, is the cost for arms and legs and wheelchairs and walking aids, this should be a extra costs.            4) I have been reading all about disability living allowance, and it seems that there is already two components now, so whay spend money the government does not have in renaming the benefit into two.            All the changes will confuse people and it just seems to me that you can changes all this because the staff do not understand the forms.            5) The answer to your question is yes it is pretty clear that some health conditions should get the benefit automatic, people who need the mobility component of the benefit should without problem continue in getting this. This is because these peoples lives will not change and without the mobility component there lives will not be the same, this can cause alot of stress            6) Mobility is the only way for full and active lives. You must keep mobility part of the benefit, has alot of the pensioners need this so they can get about with their daily lives            7) It doesn't really matter what the public really say because you already seem to think that the new assessment will take into account the conditions.            8) This is easy to answer Yes you should take into account all the aids and adapation, How can you ask this question when you want these people back into work, without the aids and adaptation you could not get a disabled person back into work            9) I understand from a number of people i have spoken to that the form is okay the way it is, why change the form when the governement do not have the money to carry this out. There is a number of professional people who can help you fill in the form.            10) There shouldn't be anymore assessment for your plan. when a person gets told they are disabled it comes from a professional person, so really it sounds that you are saying that this professional can not do their job because you do not believe that the person who you have said is disabled is the truth. Some people have been award the benefit for life this is because the people will not change, can you imagine how upsetting this is for someone like that (well clearly not)            11) Yes this will cause alot of difficulties for some people, yes it is inappropriate to carry out any assestments in the first place            12) There should be different types of reviews, people over the age of 65 should not be reviewd and if they have the benefit before 65 they should still reveive the benefit when they reached 65 or over. working age people should be reviewed for work depending on their situation, if they get the mobility part of the benefit now, they should not be reviewed because that mean their situation will not change            13) Alot of the disabled people who are claiming the benefit and are not working and they are working age, then these checks should be easily done because you already know who is not working and claiming, these people need to be checked            14) The only information these people need is that the benefit is being left alone and they will review this again over time.</p>

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	<p>15) Avoided would be people under the age of 16 and people over the 64/65 year olds. These people should carry on with no problems, you must go for the working age people.</p> <p>16) I do not think I can give you any information on this question because I do not have the benefit and I also do not have any aids etc</p> <p>17) I would have thought to have a disabled child is so upsetting for the parent, no one wants to see a child like that. How can you really answer this question because the government want to close some of the centres for these disabled people.</p> <p>?) It is very important that people have been getting DLA and should still get DLA, and all the services should stay the same.</p> <p>?) If DLA was not available and other services and benefit well I can not imagine how this will affect people. It will cause alot of illness because of stress and it will cause alot more problems with health issues</p> <p>portant that people have been getting DLA and should still get DLA, and all the services should stay the same.</p> <p>?) I can not really give anything on this because I am not disabled</p>
ONLINE143	<p>1) Cost of transport; chronic pain; lack of help; location. For me I am a retired, long term chronic pain sufferer living in the country. I cannot walk, cannot propel a wheelchair; cannot get up our rutted lane at all except by car which I can't afford to run. I had to retire early through ill health and was unable to build up an occupational pension so cannot afford taxis etc. My only social interaction with my carer has just been taken away. Because of government cuts the amount required to pay towards care has increased so much I cannot afford it so have lost both carers. I have no one to take me out and no means of getting out.</p> <p>2) The mobility payments to people in care homes are absolutely essential. To deny a person the ability to go out and meet friends in a wheelchair accessible taxi or other transport is inhumane. When it is obvious that a condition will not improve, DLA should be given for life. The three rates of care component should be maintained. Since DLA is not means tested and can supposedly be spent as needed, councils and social services should NOT be allowed to take part of that care allowance for providing home care as they are doing now. I was just reassessed and, despite our income having drastically reduced since my husband retired, have now been told I must pay an exorbitant sum towards my care costs leaving me with just £3 to use towards the extra help I need to pay someone to do like ironing, shopping etc. I simply cannot afford that on 1/3 of our previous income so the council will pay me nothing and I have lost my carers leaving me to try to prepare meals whilst lying on the floor.</p> <p>3) Transport, care needs, mobility aids. I need taxis or a larger car that I can physically get in and out of; I need home help with cleaning and cooking, ironing, shopping, keeping the garden reasonable, window cleaning, help going out socially. I need a mobility scooter as I can't manage a wheelchair; I need someone to accompany when I go out. I cannot shop so have to either pay delivery charges or pay someone to go for me. I have many medical appointments that require expensive transport, private treatments outside the NHS and a means of having some sort of a social life.</p> <p>4) Just an excuse to cut the rates paid and to reduce the number of people claiming. It will be much harder for people to claim as they will have to much much more ill. Care needs vary so much that two rates will not cover all the different cases. Look at the difference in care needs of someone in a care home with multiple disabilities and those of a person with for example a spinal problem who cannot walk without pain or sit up but who can live at home and compare that with someone who has a mental health problem. It's far too wide a gap.</p> <p>5) Absolutely certain health conditions should have automatic entitlement. Such things as arthritis, Multiple sclerosis, cerebral palsy, loss of limbs, chronic pain existing for more than say 2 years, Down's syndrome and many many others are NEVER going to get better. Cancer should mean automatic entitlement but with subsequent reviews. Despite my condition continuing now for over 10 years I have been subject to having to reapply every two years, several medicals and several times where my DLA has been refused, necessitating appeals and months of waiting for tribunals which I have always won but during the waiting period of up to 9 months I have no money at all for help. OH I got it in the end but for 9 months could not pay for carers or transport. This change will mean many more appeals much longer waiting times, more cost and more people being left without the help they need for long periods of time. To remove entitlement for people in care</p>

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	<p>homes of teh mobility component is a disgrace. These people will never have the means to leave that home or to pay anyone to take them out. A young man with cerebral palsy who needs full time care still needs to be able to get out and be mobile; needs to pay someone to go with him, taxis for his wheelchair or even to buy an electric wheelchair. This is condemning people in care homes to a life in prison.</p> <p>6) As a disabled person I need first and foremost to be able to associate with other people and not be confined to my home. This means extra transport costs, paying people to go with me; paying someone to transport me; maybe paying for a larger car that i can physically use. I need to live in a clean home and have proper meals (not microwave ready meals)which for me means carers to prepare meals for me and to help clean the house, do laundry and ironing, go shopping for me, clean my windows. It means having someone to help me wash and wash my hair more than once a week. It means assistance to go on holiday should I so choice when I cannot go alone; to be able to visit a library or a society; to help me turn over in bed and to remind me to take my medication. Since i can't get out alone and spend 99% of the year in my house, internet access is the only means i have of communicating with others. How to prioritise these people I have no idea except as now, to ask probing , intrusive personal questions like whether you can wipe your own bottom on the toilet. It is also imperative that a proper medically qualified person assess this and not just someone with a computer programme that doesn't take into account fluctuating conditions.</p> <p>7) By not using the present restrictive computer programme that ATOS is using. By actually asking people how they are on their worst days and what percentage of their life consists of those worst days. People eventually adapt to their conditions and do not realise how different their life is to "normal" people. A friend answered that she could get upstairs. The fact that she was crawling up on hands and knees and that wasn't something others do, never entered her head. The fact that she could never do that out of doors didn't occur to her. She was refused help because the computer programme couldn't take that into account.For one hour in every 4 I can just about manage to walk around the house. That's about an hour after I have taken my useless pain medication. Before and after that I can only lie down. Can I walk? Very occasionally so is the answer yes or no?</p> <p>8) No, the assessment should only assess the person not their aids because those aids may not be permanently available. If a wheelchair for instance breaks down, how can a person with no legs get to work? I spent 5 weeks bedridden this year unable to use my aids no matter what. Use of aids may depend on having a helper. I can only use my scooter when I have someone to help me. I can't depend on them being there 100% of the time.</p> <p>9) The claim form needs to be written in clearer English giving more space for people to explain their condition, especially if it fluctuates to make them feel they have had a fair chance to explain fully. The present form simply suggests that one word answers are acceptable. It is NEVER a positive experience. It is intrusive and very personal and brings home to people just how bad they are.</p> <p>10) GPs know people far better than anyone else although they rarely know how a condition affects day to day life. In that case carers or social services assessments should be accepted</p> <p>11) If this means that people have to travel to appointments it should not be so. It forces people into severe pain and difficulties. Home appointments must be provided and a witness in attendance. Interviews must be recorded for the protection of both parties. If a medical examination must be made then it must be by a healthcare professional NOT an ATOS secretary. In the case of a terminal illness a face to face meeting should not be conducted. In the case of a permanent condition people should have the security to know that they will not be constantly harassed and made to feel like criminals.</p> <p>12) There should be no reviews for permanent conditions at all. People are terrified to report a deterioration of their condition for fear of being turned down and losing what they already have. This has happened to me. The appeal process takes far too long and leaves people without the help they need.</p> <p>13) The reason that people do not report changes is the knowledge that they could lose everything. I have reported a deterioration of my condition and actually had my care component reduced for 9 months while the appeal process took place. The forms are processed by non medical staff using a tick sheet of points. If a person doesn't happen to include the wording they look for then they get turned down immediately. My own condition</p>

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	<p>has deteriorated and i need much more help but I don't dare report it for fear of losing what help I have now.</p> <p>?) Advice and information should come from outside, independent agencies. The Benefits agency can never be seen as being impartial.</p>
ONLINE144	<p>?) Support - particularly where people are "mentally" disabled or have a learning disability. It is difficult to judge the requirements unless the assessment is properly carried out. This is a barrier to providing adequate support (funding too) and all too often the support provided by carers is underestimated.</p> <p>1) There are many problems and one facing mentally (people with learning disability) disabled people is that it is impossible for most people to judge the extent of their disability - so assessing the support required is nearly always under estimated. An example is where a person "appears" nearly normal and the support provided is inadequate - this would be a danger to both the individual and society in general.</p> <p>2) For mentally disabled people the support should stay as is until circumstances dictate otherwise - people in this group cannot and are normally not properly assessed and lose of support (financial and other) can be fatal. Additionally carers providing free care would be "lost" if they cannot manage within the new boundaries - this important resource should not be lost by removing support from disabled people,</p> <p>3) Costs - support with travel (escorts), meals, dressing, and other day to day care. Extra wear and tear as they are "heavy handed". Overall support with mobility and translation (being understood), going to doctors' etc will cost extra if not provided by carers free.</p> <p>4) No - people with disabilities are complex and dividing into 2 categories could lead to incorrect awards and long term harm.</p> <p>Difficult to place people with complex disabilities (e.g. mental) which cannot easily be seen/categorised and this could lead to inaccurate award which would cause long term problems.</p> <p>5) If a person is mentally disabled and it is obvious that his circumstances are unlikely to change - as is the case for most people with learning disabilities (mental handicap) it would be a waste of resource to re-apply/re-assess ; it would make sense to retain automatic entitlement for mentally handicapped people.</p> <p>6) Usual - eating, washing, travelling, shopping and if appropriate household chores including paying bills. Having a purpose in life e.g. supervised work</p> <p>7) Ensure that when assessing people - all interested parties are fully involved e.g. carers</p>
ONLINE145	<p>1) our son has duchenne muscular dystrophy &amp; is wheelchair bound - he is 18 years old. we have a motability van, that is equipped with an electric ramp, because he has very little strength &amp; use of his hands, a heater as he cannot keep warm &amp; electric inside. this allows our son to use his bi-pap ventilator machine when he becomes unwell, it also allows to use a suction machine when he gets "chesty" &amp; breathing becomes problematic. because of all his severe needs, he cannot use public transport, where would he plug in his bi-pap machine. our son can start the day well, but become unwell so quick, we cannot predict when this will happen. our motability van allows us to take him to the hospital for his various appointments - which include a cardiologist, it also allows to access respite centre's. our motability van is a vital link to the outside world, for which our son finds very difficult to access, life would come to a standstill for him, if his one way of experiencing life is taken away from him. he has very little opportunities for him in his short life, he will not live very long but we would like him to enjoy every minute of it for as long as he can. Please do not take his link to the outside world away from him, i implore you.</p>
ONLINE146	<p>2) having two benefits DLA and AA is a waste of time, do away with the AA, so that the range of benefits in DLA are available to all, until the person has passed away, this will also help the cares or caring organisations, because the client will have the best advantage from a single benefit, while they are active and later when they are less active or even confined to their beds.</p>
ONLINE147	<p>3) Motability costs could raise if they are not near a bus stop. However its not the costs that are always the problem, its the loss of income which can be a much greater problem.</p> <p>4) I see no reason that there should not be two rates per comonent benefits. It would be easier to adminisiter</p>
ONLINE148	<p>1) General: isolation, difficulty/expense of transport to places to meet others, work places etc. Benefit required to enable disabled to meet higher transport costs.</p> <p>Specific: disabilities which result in communication difficulties, eg deafness, blindness</p>

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	<p>2) Everyone who qualifies for DLA should also qualify for PIP</p> <p>3) Adaptations to the home and equipment (non-comprehensive list of examples: walking sticks and frames, rollators (not provided on NHS), manual and powered wheelchairs, hoists, tools to help with weak hands/arms/fingers, such as to assist in opening jars, stairlifts, electrical operation of many household functions eg closing curtains or opening doors and windows, grabrails)</p> <p>Mobility: wheelchairs, scooters, adapted cars or bi/tricycles</p> <p>Deliveries</p> <p>4) Is it sufficiently flexible to support all levels of disability? Can it support disabilities which fluctuate?</p> <p>5) 12 months is too long to wait for those with permanent disabilities which it is clear will last for ever: these people should be entitled as soon as their permanent condition is diagnosed</p> <p>6) Re benefit stopping when person is in hospital/care home: their family will want to visit, and claimant will want visits, which will cost extra; if the benefit continued during hospital/care home residence, it could be put toward cost of visiting.</p> <p>7) Claimant must be assessed at worst possible stage of fluctuating condition</p> <p>8) All aids and adaptations should be taken into account. Although some are provided on NHS, there will nearly always be a better version available privately if claimant can afford it. Therefore claimant should be allowed to use benefit to purchase whatever aids/adaptation he/she wants to.</p> <p>10) Information from whatever healthcare professional knows the claimant</p> <p>11) Do doctors have time for this, especially if in claimant's home? May be preferable for such professional to support application in writing only, but he/she should still have right to appear</p> <p>12) Yes, must be flexible, particularly to support those with fluctuating conditions</p> <p>13) Regular reviews (not more than every 6 months)</p> <p>14) benefits agency should provide advice and assistance with making claims</p> <p>16) Some are provided, others must be purchased; system is still inflexible and must be made more flexible</p>
ONLINE149	<p>1) My only experience is of physically disabled people and the answer depends so much on the individual person. People with disabilities since childhood can suffer from poor educational achievement because of medication effects, time off for medical treatment, family problems getting a child to school, lack of understanding of the child's needs at school and prejudice from other children.</p> <p>Assuming, despite the odds that a child is successful in school, prejudice in the work place still exists despite any government legislation. Society as a whole would prefer disabled people to be out of sight. Few allowances are made for a person with a disability at work to work shorter hours - because travelling is difficult, getting ready in a morning takes longer, time off may be required for medical appointments, ability may be ok some days but other days affected by a painful condition which requires heavy medication and causes lost sleep and confusion. All assuming that the workplace is suitable for a disabled person.</p> <p>A person who has become disabled in later life has the added problems of suddenly not being able to do a lot of the things everyone else takes for granted. Driving, walking, dancing, shopping. Even if with difficulty some activities can be enjoyed, sometimes it is so much effort that it is easy to give up and succumb to low self esteem and depression. Even having a holiday is a problem with so little reliable information on facilities available.</p> <p>3) Often being at home 24hrs a day, just the cost of keeping warm for a person with low mobility is a big expense. A circulation problem for instance might mean sitting with legs raised for extended periods.</p> <p>Modification of privately owned property to provide walk-in shower, downstairs toilet, wide doorways, access ramps is all means tested and must be self funded if the person's family have more than a moderate amount of savings.</p> <p>Transport is a problem as public transport is expensive, not very accommodating and is not feasible without help. If the disabled person can drive, a modified car can be leased but if not a relative has to help and probably purchase a car suitable for the purpose.</p> <p>Extra home help might be required to help with cleaning, cooking etc.</p> <p>8) I think it is ridiculous to say that providing an aid such as a crutch or wheelchair negates the handicap. There may be a small minority of people who live in a modern open plan building with good access to outside and who are able to load a wheelchair into a car and drive off to work for a caring employer. Others who are not so fortunate are in constant</p>

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	<p>pain and unable to manage a wheelchair without assistance; are so heavily medicated that driving a car or electric wheelchair is out of the question and even if they could get to a workplace would find the concentration required impossible. My wife has a wheelchair which she could use to negotiate the supermarket but she would find that if on her own she could not reach things. The main reason for her having a wheelchair is so that I can assist her instead of her trying to manage on crutches.</p> <p>I think people involved in this process should try spending days in a wheelchair.</p> <p>10) The persons family doctor who knows the history should have the opportunity in clearcut cases to complete the assessment, supported by statements from carers.</p>
ONLINE150	<p>1) Prejudice is still an issue particularly for "invisible" disabilities. People with disabilities need the additional needs they have to be recognised within a fair and equitable system. The system needs to be easy to administer and understandable by the ordinary person without recourse to knowledgeable specialist individuals. Consideration should be given to the mobility needs of disabled people with respect to public transport costs.</p> <p>2) Automatic entitlement to benefit for certain conditions known to be lifelong and for which there is no known cure.</p> <p>3) Costs for aids/adaptations eg. wheelchairs, artificial limbs, transport costs, caring costs, medication.</p> <p>4) Two components seems reasonable to reflect differing levels of disability-as for easier to understand and administer-that will depend on how complex the qualifying criteria are. Some disabled people could perceive that their disability is being underestimated because they have not been awarded the "higher" rate of benefit and therefore explanations of qualifying conditions need to be clear.</p> <p>5) Lifelong conditions for which there is no known cure should give automatic entitlement. The admin costs involved for dealing with claims from these type of conditions cannot be justified eg. Downs syndrome-increased needs for children and adults are accepted by most professionals in this field, Narcolepsy-no cure and it is accepted the condition is lifelong -supervision is normally required.</p> <p>6) Who decides what constitutes " a full and active life"?? Sitting in a chair reading may be a full active life for some-this is a very subjective assessment. I would suggest it is essential to be able to attend to personal hygiene, dressing etc as a minimum.</p> <p>7) Certain lifelong incurable disabilities should have automatic entitlement. Conditions which vary can only be assessed on how the person is the majority of the time but this time period should be quite extensive eg. 6 months or a year not daily/weekly as there may be 2 or 3 good weeks followed by several months almost complete incapacity</p> <p>8) A complex area! using an aid may not give the disabled person the same ability as an able bodied person-they may be able to "get by" but should they be penalised for this? -I would suggest not-the person with an artificial limb may be able to walk but they still have a significant disability.</p> <p>9) Claims on line are a must! If medical evidence is required the applicant could be asked to submit it with their claim to speed things up. Signpost the public to "move on to box .... if this applies etc" Claims completion helpline? TV and newspaper adverts -simple, clear, concise.</p> <p>10) The disabled person, their carer and lastly the medical personnell involved in their care -medical staff can confirm the existence of a condition but will not know how the affected person is impacted on a day to day basis.</p> <p>?) A helpline should be available</p> <p>?) I understand some are available on the NHS others are funded privately. Personal Independence payment should be used for whatever the disabled person feels they need it for -we should not dictate how the benefit is spent-I am not sure what one-off cost you have in mind.</p> <p>?) More publicity is required to make the general public aware of passporting-if the public were aware that entitlement to DLA gave a passport to other entitlements they may have been more inclined to claim.</p> <p>?) See response to question 19</p> <p>?) The need to reduce fraud is an issue BUT this should not be at the expense of genuinely disabled persons-benefits, whatever they may be, should be simple to understand and easy to claim -a degree in medicine should not be a requirement of completing a disability</p>

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	<p>allowance claim form!</p> <p>?) The parents of children with a disability may have considerable difficulty with transport - this has never been considered within DLA but is a factor we should take into consideration eg.additional costs involved in taking the child to hospital etc for treatment or healthchecks. The needs children would ordinarily have must be factored in. Each case would need to be taken on merit-children develop at different rates and therefore needs may differ considerably from child to child.</p> <p>?) There could be duplication of effort in confirming the existance of medical conditions etc- In the utopian world of The Big Society information should be available cross government to negate the possibility of the public having to go over the same scenario with several different organisations. Local/National government shold share infomration ( with the applicants permission)</p> <p>?) There will always be a minority of the public who do not want to claim benefit as they see it as charity -advice and support may help with this.</p> <p>Key features:Phone/online help service-avoid insisting people come for interview or are visited in their homes-this can be offputting.</p>
ONLINE151	<p>1) This depends on the nature and severity of the disability. My daughter has profound and multiple learning difficulties and complex physcal needs and requires one-to-one for all her needs. She has a very large non-folding wheelchair and travels in her chair. Wheelchair access is a major problem but so is public transport. I feel very vulnerable driving my wheelchair accessible vehicle (WAV). If something were to happen with the car, we would be totally housebound. Garages do not have WAVs as courtesy cars. Holidays abroad are practicaly impossible. There are problems with getting my daughter on the plane, will the airline agree to take the wheelchair, will there be a wheelchair taxi to get us to the resort and will the resort and accommodation be wheelchair fiendly? Hospital apointments are difficult. Hospitals are usually not set up to use mobile hoists so their staff have to help me lift my daughter. They are within their rights to refuse to do this but I cannot lift alone. We have appointments in London which means a 2 hour trip door to door via the train. It is a real headache to contemplate travelling with a large wheelchair by train. Can we get to the platform without steps? How large is the gap between the train and the platform? Can we find the wheelchair compartment and get on it in time? Can we get off the train or is the gap too big? We can't get into a taxi and so we have to push the heavy wheelchair 35 minutes down the road to the hospital. The train fare is more than double that time in the morning. Why can't London hospitals be set up so we can do a conference call from our local hospital? Motability is a great scheme but grossly unfair. The more disabled you are, the more you have to pay for the vehicle. Maybe the scheme could be totally revamped to only accomodate disabled people/ children who need adapted vehicles, and with little or no charge for them. Disabled people who can travel in normal cars can get a car for a nil advance payment. People that need adaptations have to pay a lot more for them. We are a normal sized family of 5 but our daughter is severely disabled. Although there are small WAVs available on a low advance payment, they are far too small for us and we have to pay several thousand pounds ( our 1st car cost us £16000 and the 2nd £6000) We don't get help because we are not eligible for a grant. This is unfair. Why should we have to pay thousands and disabled people who can travel in normal cars, get them sometimes free? The proposal to stop mobility allowance for people in residential homes needs to be carefully thought out. It is likely that our daughter will live in a residential home when she is 18. However we will want her to come home at weekends, come out on day trips and come on holiday. How can we do that without a WAV? If she doesn't get mobility allowance, we will not be able to afford a WAV. You could reduce the mobility payments drastically for disabled people living in residential care who can travel in normal cars. They only need a small income to pay for a taxi once or twice a week, whereas without a WAV we will not be able to bring our daughter home. There should be a difference in the DLA for people who are wheelchair dependent and require one-to-one for care needs, as opposed to people who can stand up and walk around and can do personal care on their own or with a little help. The scheme seems unfair. My child gets the higher rate and fully deserves it. A child in main stream school with no physical or learning disability but who has mild aspergers and wets the bed - also gets the higher rate - how can that be? Some people know how to fill in the forms in their favour - other people are not seeking help with filling in the form when they should, because they are not getting the DLA they are entitled to. There are few leisure activities available to suit my daughter. She needs sensory stimulation and enjoys sensory rooms. If there are no such local venues, then this should be taken into account in</p>

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	<p>the DLA payment ie extra money to help fund a sensory room in the home or WAVs to get to sensory rooms outside the local area. Toileting is a major issue. If we are out we have to cut short our trip because our daughter requires a changing bed which are exceptionally few and far between. Hoisting is also an issue wherever we go because it is non-existent. We need 2 people to lift our daughter so if I am on my own, my daughter either has to stay in her chair or we have to come home.</p> <p>2) The 3 rates are a good idea to take account of the wide range and degrees of disabilities. There is a vast difference between my daughter with profound and multiple learning difficulties and complex physical needs who needs and gets the higher rate DLA and someone who is mobile but requires a stick and is slow to walk around but can do their own personal care - (incidentally I know of one such person who does in fact also get the higher rate and thus a motability car). I fear that if there are only 2 rates, those on the lower rate will not be entitled to any DLA and thus you are putting them on a par with non-disabled people which is grossly unfair. There should remain the 2 elements - personal care and mobility but I think the higher rate mobility should be looked at more carefully. Higher rate mobility should be for those who cannot get about without a wheelchair or adaptations to a car. Those without wheelchairs who can get about in normal car should get a lower rate.</p> <p>3) This depends on the nature and severity of the disability. Clothing is an issue for us - it has to be wheelchair friendly, elastic waistbands and large bottom area to take account of incontinence pads. Wheelchairs - we are provided with a chair but it is not suitable for all outings - walks in the woods, up and down hills, can't fold it up and put in a non-WAV. Folding special needs buggies are extremely expensive and so we have to go without and our trips out are limited. Transport is expensive - our current WAV cost us £6000 through Motability and the previous one cost us £16000. Toys - special needs and adapted toys are very expensive and difficult to find.</p> <p>4) Two rates would make it easier to understand and administer but I do not agree that appropriate levels of support will be maintained. The wide range and degrees of severity of different disabled people surely cannot fairly fall into just 2 categories. I fear that those eligible for the lowest rate currently will lose out totally and that would put them on par with non-disabled people which is grossly unfair.</p> <p>5) There could be some automatic entitlement to speed things up - perhaps a few simple questions by telephone to the GP - to confirm whether the applicant is wheelchair bound, has severe/profound learning difficulties, deaf, blind, unable to do their own personal care. Generally however individual's with the same disability will have varying needs.</p> <p>6) Care needs are a priority as is transport. The right to an education, to work and to enjoy leisure activities.</p> <p>7) The GP should give a fair assessment of the likelihood of a condition changing and there should be a system whereby GPs can automatically report changes and otherwise a short questionnaire (1 page) sent out to claimants every 3 months.</p> <p>8) Aids and adaptations should only be taken into account to speed up the application process ie if someone uses a hoist at home and has a WAV they should automatically get the higher rate mobility and care. Aids and adaptations should not be taken into account to reduce the DLA they are entitled to. People are still disabled whether they have aids and adaptations or not. Such equipment might make it easier for people to live their lives, but it does not put them on a par with non-disabled people. They cannot live full and active lives in the same way as non-disabled people. They are slower to do things because they have to use their aids and adaptations. They would achieve more if they did not have to rely on such equipment and what happens when the equipment breaks down? They are still disabled but are now prevented from leading full and active lives. If the suggestion is that a greater allowance should go to people who need to obtain aids and adaptations, then this would be difficult to administer fairly. Most local authorities will loan equipment but this varies considerably depending on where you live. Adaptations to the home are means-tested (except for children) so disabled people should not be penalised because they need adaptations and aids and are assessed by you as eligible for them, but in reality they cannot obtain them because they cannot afford to pay for them themselves. Also there is a waiting list in trying to get equipment.</p> <p>9) The form should be much shorter - not 40 pages long - no more than 10 pages - ideally 6. Information should be available in easier to read, short leaflets and booklets placed in libraries, GP surgeries, hospitals, and other public places.</p> <p>10) For children it will be mainly the paediatrician but there will be other consultants</p>

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	<p>involved depending on the nature of the children's medical conditions. I have found that hospitals are not great at passing on information to GPs, but also, as we are encouraged to see the 1st available GP at the surgery rather than our registered one, it is quite likely that our GP will not know us or understand the full implications of our disability. Perhaps the applicant could suggest suitable professionals who can put forward evidence ie physiotherapists, occupational therapists, specialist nurses, speech &amp; language therapists, teachers, teachers for the visual and hearing impaired, hospital consultants, social workers or other social support workers you have dealings with. The difficulty will be that these professionals are already over worked and so there will be huge delays in them submitting their reports. Could they be telephone contacted to speed up the process?</p> <p>11) If the health care professional does not know the applicant then they will not be fully aware of the full implications and nature of the disability. It will be down to the applicant to mention everything, which will be difficult under pressure. When filling in a form at least you can spend a much time as you need and go back and add to it before you send it off. The disabled person may need someone with them to help. A meeting at home or in a place where they spend their time will be most useful - not at a location they do not of, which might make them feel uncomfortable and unresponsive.</p> <p>It would be inappropriate to have a face-to-face meeting with a person with a terminal diagnosis, or with someone whose disabilities are</p> <p>12) There should not be any reviews in certain circumstances - ie my daughter's condition is not going to change - she has profound and multiple learning difficulties and complex health needs, she is wheelchair dependent, cannot weight-bear and uses a hoist and travels in her wheelchair. If a condition is likely to change then a health professional at the start should identify the likelihood of this happening and an expected time-scale. Rather than completing the initial application again in the review, several short questions could be asked, but again the health professional needs to be involved in the review process - ideally by telephone.</p> <p>13) There should be a system whereby GPs automatically update and inform the DLA of changes so that the DLA is not dependent on applicants getting in touch voluntarily. Some disabled people may not manage their own affairs in which case they cannot be penalised for failing to get in touch. There shouldn't be an obligation on the staff at a care home, or a personal assistant employed by the disabled person through direct payments, to contact the DLA about changes.</p> <p>?) I only know what happens with disabled children. Different LAs will loan different equipment, and some LAs will class some equipment as an adaptation and thus you need to apply for a Disabled Facilities Grant before you are entitled to receive that equipment. The policy differs depending on where you live, eg some LAs will provide a special bed, others say it's up to the NHS to do that. If equipment is refused, the family need to buy it themselves if they are able to, or perhaps fund raise or apply to a charity. It would be helpful if equipment could be hired and the fee paid for out of DLA, eg we want a folding supportive buggy so that we can take a holiday abroad - but we don't have £2000 to spend on one. If we could hire one short-term, that would solve our problem. I don't see how we could use the Personal Independence Payment to meet a one-off cost, unless we were given an extra payment to cover that cost. The DLA we receive is used for everyday living and there isn't any left over to pay for equipment.</p> <p>?) I really hope that the views of those responding to this consultation are taken seriously because we are the ones directly affected by disability and we know exactly how difficult our lives are compared to non-disabled people.</p> <p>Thank you</p> <p>?) More time, expense, energy and effort would be involved in finding out about other services and benefits, whether you are eligible and how to claim them. Our lives are difficult enough as they are without this simple thing being removed.</p> <p>?) Obtaining a Motability car has been a lifeline. Also getting a Blue Badge and an exempt tax disc sent through the post automatically. The arrangements for Congestion Charging are useful if you go to London. I have been able to get a leisure access car locally but it would be helpful if the cinema access card was free instead of having to buy one every year. Local passport information should be included in the DLA booklet to be held in public places. I have also obtained Carers allowance which was made much easier.</p> <p>?) The fact that children are growing up and their needs are changing, but also that they are likely to live with a family with other siblings. The needs of the disabled child has a great impact on the family as a whole - ie the limits on what activities the family can do, the</p>

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	<p>places they can go, the transport they can access, the holidays an trips out they can enjoy. Parents are anxious that their non-disabled children should not be unfairly affected by their sibling's disability, but this will always be impossible unless there are better facilities, access, transport, respite and paid care and help in the home.</p> <p>?) This would be difficult to enforce. How can you identify those people who need advice and won't bother applying for much needed benefit if they don't get that advice? There mustn't be a requiremnt for all applicants to get advice because the advice services are inundated already.</p> <p>?) Whether they are eligible in the 1st place and what the rates are and how much is paid - so applicants can decide whether it is worth the trouble applying or not. This information must be available in an easy to read and easily available format, in public places such as libraries and GP surgeries and hospitals and must also be included in the application pack.</p>
ONLINE152	<p>1) The responses I have made in this Chapter are basically my own but are also on behalf of the Perth ME Support Group, and with additional comments from other members. The Group as a whole agreed at a meeting that I should lobby on their behalf and they were emailed these reponses and asked for comments, and additions, which I have acted on.</p> <p>Problems and Barriers: Lack of energy/fatigue, pain and, cognitive problems/confusion, overlord from light, noise, feeling ill/fluey, etc. before doing anything. But maily lack of physical and mental energy. Energy is needed to do everything from eating to sitting upright to playing sport. Lack of energy can be more disabling than almost anything else, yet is not seen. [REDACTED], with two prosthetic legs, could enjoy a round of golf and a night in the pub, walking from room to room was difficult for me and eating out sheer torture - to try to sit upright at the table and eat, cope with the noise and the lights and movement. It was for me an extreme endurance test. Moderate to severely affected ME/CFS patients are extremely debilitated: "I have treated more than 2,000 AIDS and CFS patients in my career. And the CFS patients are MORE sick and MORE disabled every single day than my AIDS patients are, except for the last two months of life!"</p> <p>€“ Dr. Marc Loveless (infectious disease specialist and head of the CFS and AIDS Clinic at Oregon Health Sciences University, in Congressional Testimony, CFS Awareness Day, May 12, 1995) A friend going through cancer treatment was suddenly very sympathetic and said she didn't know how I coped with this level of fatigue, but from what she said her fatigue was not as severe as mine. A mother who had a child with ME said that going through the diagnosis and treatment for her breast cancer was €œa walk in the park €□ by comparison with what her daughter suffered.</p> <ol style="list-style-type: none"> <li>2. Lack of energy/fatigue etc as a consequence of activity.</li> <li>3. Unpredictability of the illness is also disabling, as one cannot plan in advance, or have to cancel at the last minute: makes one unreliable.</li> <li>4. The length of time it takes to do simple tasks due to the need for frequent rests, and forgetfulness is also disabling and one gets distracted easily and forgets what one was doing, jobs don't get finished for both reasons and as one has little energy to start with one can only do in a day a small percentage of what a healthy person can achieve.</li> <li>5. Dizziness and passing out when standing due to orthostatic intolerance.</li> <li>6. Poor short-term memory.</li> <li>7. Noisy places and people lead to headaches, inability to process information, is exhausting and leads to feeling unbearably unwell.</li> <li>8. Flickering/flashing lights have similar effects to Noisy places. Both of these are similar to the overload of sensations that autistic people experience because they cannot filter out information.</li> <li>9. Upright chairs/seats and no footrest - I need my knees higher than my hips, due to orthostatic intolerance, and my body supported for example on buses, in offices, in waiting rooms etc. O.I. is a very common feature of ME and the resulting lack of blood to the brain is debilitating, makes one feel very unwell and makes cognition poor etc - it is like being in shock.</li> <li>10. Having to stand in a queue (feel very unwell, passout due to Orthostatic Intolerance)</li> <li>11. Being in a group -- this requires too much concentration, to process in full and quickly enough to take part, properly.</li> <li>12. Lack of understanding/prejudice of others</li> <li>13. Lack of facilities in shops etc to rest.</li> </ol>

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	<p>14. For some, anxiety and panic attacks are debilitating possibly due to an abnormal amount of neuropeptide Y being produced by the body. This is a biological abnormality not a psychological one. "Plasma neuropeptide Y: a biomarker for symptom severity in chronic fatigue syndrome" Behavioral and Brain Functions 2010, 6:76 doi:10.1186/1744-9081-6-76 by Fletcher et al. Also because the body is so ill and under stress due to that the stress chemicals are released in the body resulting in the symptoms of anxiety even if one is not thinking anxious thoughts.</p> <p>15. Children/teenagers growing up suffering from ME, which is the largest cause of school absences, and with other debilitating conditions, may be unable to complete their education because of the lack of resources to suit their variable needs and miss out on forming adult relationships because of the illness affecting them in their formative years, this all impacts on their ability to function well as adults in society, either as wage earners or parents.</p> <p>Being immature in some aspects of their lives and much more mature in others because of their difficult experiences may be quite debilitating in social/work situations.</p> <p>16. Pain: constant aching of muscles/joints/soft tissues, severe pain when using muscles, severe headaches often unresponsive/minimally responsive to painkillers</p> <p>17. confusion</p> <p>18. Some people suffer from severe balance problems which make mobility and functioning around their homes extremely difficult nevermind outwith the home. They are very unsafe as well as feeling very unwell.</p> <p>?) In addition to what i have have previously said: children/teenagers suffering from ME, the largest cause of school absences, and other debilitating conditions, may be unable to complete their education because of the lack of resources to suit their variable needs and miss out on forming adult relationships because of the illness affecting them in their formative years, this all impacts on their ability to function well as adults in society, either as wage earners or parents.</p> <p>?) Please bear in mind that young people who have been isolated from their peers and society by a medical condition or illnesses such as ME are further debilitated by lack of social development and schooling and may not know how to react or behave in 'normal' situations even once the illness improves. Such inexperience in itself can be extremely debilitating.</p> <p>2) 1. Non-means tested</p> <p>2. T3) 1. Food: getting and cooking food and washing up. It is important to eat healthily and home cooked food is best, yet for many reasons many of us cannot do all this. Ready meals on the whole are unhealthy, and expensive, as are carryout meals especially if we need them delivered, therefore, may have to pay for someone to cook food for us and to pay for shopping to be delivered or employ someone to do the shopping, cook the food and wash up.</p> <p>2. Laundry: due to night sweats when the body, bedding and night clothes get wet; continence problems; spills from clumsiness. PWME may be also unable to change one's bedclothes oneself.</p> <p>3. Heating: on most of the time. I am very cold and am in the house most of the time so need the heating on for longer and up higher.</p> <p>4. Mobility: need door-to-door transport in order to go out and enjoy company, get to medical appointments, and do essential shopping, go to meetings. My car is an essential, and one of the things that enables me to feel normal and on a par with others. However, to go outside of the town I often need to be driven, for safety due to cognitive problems either at the time or as the result of travelling and/or doing whatever I've gone for, e.g. a meeting. I would not be safe to drive home after a meeting nor would I have the energy left to get the most benefit from a meeting if I drove there myself.</p> <p>5. Alternative/complementary medicines and therapies e.g. vitamins, minerals, osteopathy, massage, etc all of which may help with symptoms</p> <p>6. Paying someone to do things I used to do myself from housework to painting and decorating ie home maintenance -- it doesn't happen otherwise. It is important for physical health and hygiene and morale that surroundings are clean and pleasant and work properly.</p> <p>7. Internet access is essential as is the phone in order to have communication with the outside world when one is more or less housebound</p> <p>8. Paying for a community alarm system when one lives alone. here is no point in retesting</p>

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	<p>people who are on maximum benefit and who have static or deteriorating conditions. Under these circumstances the benefit should be available for a life, unless there are huge advances in treatment.</p> <p>3. There should be a minimum of three levels of care as there are many degrees of care required by people with different levels of disability where even a small amount of additional income can make a huge difference to the quality of life when one cannot do things oneself that one could do if one was fully able-bodied or well.</p> <p>4. There are conditions for which certain levels of benefit should be automatically available, for example having no arms.</p> <p>4) Absolutely not!  There are many levels or degrees of disability for which different levels of care are required, from 24 hours a day to a few hours per week. To receive less care than one needs, at any level, is distressing and damaging to one's health. This is a concept which is simple to understand.</p> <p>With only two levels of the care component of this benefit many, many people, who need it, will not get it. This would mean the difference between recovery and permanent and possibly deteriorating ill-health for ME people. This is at best unfair, and at worst either a false economy or cruel.</p> <p>It is perhaps easier to understand how and why you qualify for a level of care if there are more levels to choose from and this would certainly be fairer. Also for an Assessor it would probably be easier to select the correct level of care if there are more to choose from -- everyone is familiar with a five-point scale, marking out of 10 or giving a percentage score. It could be based on the number of hours help one needs in an average week.</p> <p>With only two levels of care it may be that many people are given much more financial support than they need!</p> <p>5) There are bound to be conditions which are fixed or deteriorating which should automatically qualify, such as having no arms, being totally blind, or suffering multiple seizures a day, or being severely autistic. In a condition like ME if one has not made any improvement in the first 5 years the prognosis is not very good, and perhaps at that point one should be, infrequently re-accessed especially as the assessment process itself is extremely stressful and will probably cause a relapse. Unless there are medical breakthroughs it seems unnecessary to re-assess patients who are unlikely to get any better.</p> <p>6) I don't know, but some recognition should be given to people who live alone and have no one to help care for them, as they have to pay for the help which would normally be given by a partner or other family members.</p> <p>Which activities are most essential for everyday life?  Food: getting and eating healthy food and clearing up afterwards, so that one has the best chance of recovery in a hygienic environment  Warmth, safety, and cleanliness.  We are social human beings who require contact with other people, therefore the ability to socialise with friends and family in person, over the phone, or Internet.  Having pain and other health problems eased.  The need for attention, to both give and receive it, and for friendship, fun, love, intimacy  Having a sense of autonomy of control over your life is vital for mental health  The opportunity to be creative and/or to do activities that are enjoyable  The need for meaning, including spiritual welfare  (See Human Givens by Joe Griffen and Ivan Tyrrell, and Maslow's Hierarchy of Needs, as well as personal experience.)</p> <p>7) I don't know. Personally I have a GP who is not well educated in ME, I have no specific consultant and there are no ME/CFS clinics to attend, so a medical report is unlikely to be accurate or helpful, particularly as the GP doesn't really know me or ask about daily problems.</p> <p>The system needs to be made to fit us and not try and force us into an inappropriate and inflexible system. We need to be believed -- attitudes that we are all scroungers needs to go. Everyone I know who has claimed the DLA has hated doing it and many have put it off for years at great cost to themselves and some who are eligible have never claimed, because they cannot cope with the stress of the system and of, in effect, being regarded as liars.</p> <p>As I live alone, the only person who can provide accurate information about the condition and how it affects me is myself - I need to be believed. Friends and relatives only see me</p>

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	<p>on good days when I am well enough to cope with social activity.  For DLA, keeping a diary for a couple of weeks really helped at tribunals, plus letters from friends and family but also although they don't know the true picture they have a better idea than the medical profession.  Assessment questions have to be asked about what happens over a couple of weeks or months in order to get a true picture. Even then memory problems will interfere with an ME person being able to give a full picture. Assessors and health care professionals involved in the assessment should quickly begin to develop a sense the 'ring of truth' if claimants are allowed to tell their own stories.</p> <p>8) Don't know. I have little personal experience of what this question might be referring to, but if a disabled/ill person does need aids and adaptations, given that the reason for DLA/PIP is to create a level playing field between those who are fully able-bodied and those who are disabled the cost of these should be met through this benefit. Some aids and adaptations are not very helpful, may cause pain etc so it should not be assumed that they are of real benefit.</p> <p>9) Accept that the majority of claimants are genuinely ill/disabled, are not scroungers or liars, and treat people with respect, whilst being aware that there always be untruthful people in any group, as MPs have so remarkably demonstrated, with their expenses, but they don't like being tarred with the same brush.  It is unacceptable for the government to have a target of reducing the benefit bill by 20% when there is no research proving that 20% of the value of claims is fraudulent. It is unacceptable to try to cull large proportion of disabled people for financial savings even if this cull is only on paper.  Make claim form easier to fill in by:  1. Making the questions simple and easy to understand.  2. Explaining what is meant and using examples.  3. Allowing people to tell their own story and give examples of the difficulties they face.  4. Not trying to get people to fit into someone's preconceived ideas of what constitutes disability.</p> <p>10) This is very dependent on the condition and how well understood it is by health professionals: it could be a GP who really knows the patient well, a consultant, physiotherapist, occupational therapist, CPN or none of these. The individual who is claiming and their family or friends may have a better idea than any health care professional could ever have of the individual needs. For someone living alone he/she may be the only person who has any true idea of the struggles s/he has in daily living; of the needs that are not met; of cognitive and physical problems s/he faces, in which case a diary may be the only supporting evidence that can be provided, if the person is capable of providing one.</p> <p>11) Benefits: they might be able to draw out more relevant information.</p> <p>Difficulties: HCP may have no insight or understanding of the condition, no expertise in it and have been given wrong training for example for ME, where much of the training material seems to be based on the false assumptions of the Wesselyan School of thought that people are ill due to false beliefs and deconditioning and require CBT and Graded exercise therapy whereas both of these have been found unhelpful but in particular Graded Exercise Therapy can be very harmful, Maes and Twisk; Nunez et al; Surveys by the ME Ass. and AfME (see refs below) On the other hand there are thousands of pieces of research showing physical abnormalities from muscle recovery times to reduced blood flow to the brain. (There are too many to reference but a look at ME Research UK's Website, or any other ME Charity's website would be a good place to start.) There is also evidence of inflammation of the CNS at post mortem: <a href="http://www.meassociation.org.uk/wp-content/uploads/2011/01/Chronic-Fatigue-Syndrome-Abstract-DGOD-v2.doc">http://www.meassociation.org.uk/wp-content/uploads/2011/01/Chronic-Fatigue-Syndrome-Abstract-DGOD-v2.doc</a></p> <p>HCP may be more interested in form filling than finding out the genuine difficulties of the claimant.</p> <p>HCP may get a very incomplete picture due to time constraints and not asking appropriate questions.</p> <p>For someone with ME cognitive problems both in understanding and in memory are worse under stress and the PWME may not give the appropriate information, due to this.</p>

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	<p>HCP may get a false impression due the claimant being on an adrenaline high which looks as if the claimant has more energy than they actually do and lead to a 'crash' later where they are very unwell. Initially, patients are often excited about seeing me, their adrenaline pumping and a physician who saw some of these patients for only up to an hour would reasonably conclude that they were high-energy patients with nothing wrong. This is misleading. During the course of a day's examination, the patient may change from a brighter than normal person to one who resembles a blank-faced zombie, a patient who can talk and walk only with difficulty or not at all. Sometimes their voices become scanning, and they begin verbally to stumble. Sometimes the patients are fine all day but when I see them on the second day, they have often, in physical and intellectual terms, gone to pieces. A one-hour physical examination will rarely pick up ME/CFS pathology. Byron Hyde, ME/CFS Specialist, Ch 3, Handbook of Chronic Fatigue Syndrome, Jason, Fennell and Taylor, published by John Wiley and Sons, Inc 20</p> <p>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 another location:</p> <ol style="list-style-type: none"> <li>1. Where the person is terminally ill</li> <li>2. Where the person is upset by strangers e.g. severe autism</li> <li>3. With the diagnosis and/or disabilities are clear and are not going to improve, or the prognosis is such that the person is unlikely to improve.</li> <li>4. where the person has a condition that would be made worse by such a visit eg severe ME where the person is bedbound and too ill for visitors.</li> </ol> <p>Refs:</p> <ol style="list-style-type: none"> <li>1. Maes and Twisk 'Chronic fatigue syndrome: Harvey and Wessely's (bio)psychosocial model versus a bio(psychosocial) model based on inflammatory and oxidative and nitrosative stress pathways.' BMC Medicine 2010, 8:35doi:10.1186/1741-7015-8-35</li> <li>2. Nunez et al 'Health-related quality of life in patients with chronic fatigue syndrome: group cognitive behavioural therapy and graded exercise versus usual treatment. A randomised controlled trial with 1 year of follow-up' Clinical Rheumatology DOI: 10.1007/s10067-010-1677-yOnline First</li> <li>3. MEA Survey <a href="http://www.meassociation.org.uk/wp-content/uploads/2010/09/2010-survey-report-lo-res10.pdf">http://www.meassociation.org.uk/wp-content/uploads/2010/09/2010-survey-report-lo-res10.pdf</a></li> <li>4. AfME Survey <a href="http://www.afme.org.uk/res/img/resources/Survey%20Summary%20Report%202008.pdf">http://www.afme.org.uk/res/img/resources/Survey%20Summary%20Report%202008.pdf</a> Continuing Medical Education Programme</li> <li>5. Chronic Fatigue Syndrome - Guidelines for the Disability Analyst Module 6(DWP) Seven of the 8 references used are of the Wesselyan school of thought. The eighth is the Chief Medical advisers expert group which included Wesselyans</li> </ol> <p>12) Frequency of reviews should be determined by the likelihood of improvement, where there is little likelihood of improvement there is little point in reviewing the individual's needs unless he/she may be eligible for a higher rate of benefit. Reviews are highly stressful for claimants over quite a long period so the fewer there are the better.</p> <p>Perhaps the GP/consultant or other appropriate person could be asked if s/he has noticed any significant improvement over the last year or other suitable period of time, and if the answer is 'no' then no more should happen. For conditions which improve very, very slowly the review time could be suitably extended.</p> <p>13) It is extremely difficult to adapt to a sudden loss of income. The fact that there will be only two care rates will make this reporting problem worse. With more grades of care and rates of benefit people may be more willing to go to a lower rate as they improve rather than lose benefit altogether or face a large drop in income. Also, as someone improves they are more likely to be able to begin earning by doing a small number of hours work per week, or earn slightly more by increasing hours worked, to make up for the loss of benefits. To encourage the reporting of improvement, therefore, a gradual reduction/removal in benefit would make 'reporting problems' easier for the claimant.</p> <p>?) Requirement -- absolutely not! People in this country should have the right to choose what is right for them. Perhaps the option of a referral such as one might get to a consultant, OT, or Physio, to someone who could explain PIP might be appropriate.</p> <p>?) cannot achieve that by reducing the budget by 20%. If that reduction goes ahead 100,000s of people will have their barriers raised, reduction in essential income will lead to</p>

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	<p>increased stress, which is a precursor to depression and further difficulties. Stress is also one of the major contributors to making ME/CFS worse</p> <p>It is not true that numbers claiming benefits due to illness and disability are continuing to rise. Richard Berthoud of the Institute for Social and Economic Research, in the ISER Working Paper Series entitled "Trends in the Employment of Disabled People in Britain", published in Jan 2011 found that the trend started to level out in 1995 and seems to have been falling since 2005. Therefore, the premise that a continuing steep rise in claims for DLA/PIP is false.</p> <p>I don't know what the situation is with regard to ESA and savings, but currently on I.S. once one has savings of £6,000 the benefit reduces. This means that one cannot save up enough of one's mobility component of DLA to buy a new car, yet one can lease one. I would rather own my own car as I would continue to need it if I improved and no longer qualified for DLA or the benefit was suddenly stopped. As DLA is not means tested it should not count for IS either. So I would say that one should be able to save up PIP to use it in a way that is best for the individual, ie if there is a savings limit for ESA, any income or savings from PIP should be excluded from that limit. It is easy to do if PIP goes into a separate account</p> <p>Likewise, any substantial amount of backdated payments should not have a time limit on them before they are counted as savings and IS or ESA reduced. I was too ill to spend four years of back dated money within one year and consequently lost out and was very, very stressed when I badly needed the money before the appeal was won and then was penalised for being too ill to spend it in one year by having my IS reduced. The rules make one profligate, which I abhor, then one cannot save for what one really needs to improve the dreadful quality of life and improve one's chances of healing.</p> <p>If the condition is not going to improve then there is no need for a review unless deterioration would qualify for a higher rate of benefit.</p> <p>?) Please bear in mind that young people who have been isolated from their peers and society by a medical condition or illnesses such as ME are further debilitated by lack of social development and schooling and may not know how to react or behave in normal situations even once the illness improves. Such inexperience in itself can be extremely debilitating.</p> <p>?) I prefer to buy outright rather than lease - that way I know it won't be taken from me when I need it or no</p> <p>Re one off costs: Perhaps the form of a grant for some items and for their maintenance, upgrading and replacement might be more appropriate than PIP. There are seldom one-off costs as equipment needs to be maintained, upgraded, replaced and this should be allowed for, to create a level playing field that is the raison d'être for DLA, and presumably for its successor.</p> <p>?) Legal jargon should be explained, examples should be given of the type of information requested and as for DLA it is helpful to have someone who understands the process to help the claimant fill in the form.</p> <p>?) On a personal level the only entitlements have been a bus pass and car tax exemption. I had to apply for the car tax exemption separately and travel to the next city to get the disc the first time. I think this process should be easier. If you are a car driver there should be a box you can tick so that the exemption certificates could be sent automatically when the award is made. Similarly for a blue badge - one should not have to apply for this separately.</p> <p>?) The proposal to remove mobility payments from those in residential care is discrimination against a group of disabled people least able to defend themselves and is intolerable and unjust. This proposal would leave this vulnerable group prisoners in their homes and unable to take part in society, and remove from them something which is essential for mental well-being i.e. some control over their lives, plus there would be a loss of variety of scenery, people and experiences, which are also vital to mental well-being. Such a loss would be an appalling reduction in the quality of already blighted lives.</p>
ONLINE153	<p>1) I work for the stroke association and for some of my clients that is the only help of financial support they get</p> <p>Is this really the right way to go about it and to recover the country deficit?</p> <p>3) Extra help, support, which in turn means their cost of living has to go up, they may need to adapt their home in order to try and live independently.</p>

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ONLINE154	<p>1) DLA at present does not help people access services that offer practical help, people are left to contact social services or occupational health on their own and are often unaware these services are available. Entitlement to higher rates of DLA has helped people acquire more benefits because there are so many available and overlapping each other. Awards are often given because a person qualifies for incapacity or DLA etc. It would be simpler to have just one benefit based on one assessment and a limit set on how much can be paid. If rates remain too high there will be no incentive to move off benefits</p> <p>3) Benefits, incapacity or ESA, industrial injuries, DLA, disability premiums, any health related benefits should be combined. The initial claim could start from what is required to ensure the person is independent in their home and at work. Employment advice and help should be the first consideration followed by practical help in the home for those unable to work. There is no reason why the assessment could not be shared with employment advisers, occupational health, adult care services or anyone involved with the individual</p> <p>4) hopefully the difference between the two rates will be clear to everyone, there is a lot of confusion and disagreement currently between the rates for DLA and AA. The mobility component in particular is difficult for some customers to understand and leads to additional costs in disputes and appeal.</p> <p>5) some health conditions are severe and lifelong, once established there is no reason why they should not attract automatic entitlement. Severe learning and development disabilities for example, these people need considerable help and support. There may be a very few conditions that could mean automatic entitlement, hopefully the medical people and the disability advisors could identify these</p> <p>6) The initial claim should undergo a full assessment with trained advisors. If a person is capable or working and supporting themselves then every effort should be made to help the person into work. The government needs to make sure jobs are available so everyone has a chance to work regardless of age or health. Essentials for daily life are hygiene and nutrition. Occupational health already help by providing aids for those who have a need from toilet rails to a walk in shower. The current main meal award DLA is outdated. Many homes use a microwave, buy frozen produce, prepared food. Many homes use online shopping. If a disabled person has no access to preparing a meal through any means, this would have to be provided for them. Most of the current care type questions are outdated. There are aids for most of the activities of daily living, and these should be the first consideration when providing support for the person in their own home rather than money which does not help them in any way</p> <p>8) Yes if someone can manage an activity with an aid I don't see any point in taking that into account for a financial assessment.</p> <p>12) I believe doctors and health professionals are in the best position to decide on duration of awards. The medical people have the best idea of likely progress of conditions and times scales for possible improvements. Every case should be considered individually to take into account other factors, treatment, other conditions or disabilities</p> <p>17) Key factors should include the help already in place. Children in particular receive help from more than one source. Various therapies are given in school, physio, speech, language, psychological and many more. Support is given through extra teaching and learning assistants. Transport is often provided to and from school. All of these are funded by the Local Authority whilst the parent/guardians receive the benefits. It could be considered whether the payments to parents are in fact doubling costs in some cases. If care and transport are provided, any award should go toward these costs. Parents of children in residential schools often have mobility allowance or a motability car when it is the school who provides transport. As children are in school most of the day we should be considering what extra costs are incurred. As with adults any aids required are often provided free of charge ie incontinence pads, walking aids, bath or bed rails</p> <p>?) Too many benefits and high rates often mean the person is better off on benefits. Disabled people on benefits are not automatically offered help with employment opportunities or access to voluntary organisations, social clubs or resource centres.</p> <p>?) people are better off on benefits, have a better standard of living without the need to work. There are too many benefits available and the amounts paid are often higher than an average person can earn, there is no incentive to be out participating in and taking an active part in society. With the DDA and adaptations to work places and public buildings and transport, there is no reason for anyone to choose to stay at home</p>

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ONLINE155	<p>1) Not enough support in the workplace or at college, not being able to get interviews, not enough housing ie/supported housing and help to enjoy social and leisure activities</p> <p>2) It should not be messed with at all it should stay as it is</p> <p>3) they still have to buy food pay for gas and electricity housing, also extra costs in employing help they might have to buy special aids equipment etc</p> <p>4) Make forms harder to understand and fill in the current one is bad enough</p> <p>5) Some health conditions or impairments should mean an automatic entitlement to benefits</p>
ONLINE156	<p>1) lack of consistant care provision within nhs.</p>
ONLINE157	<p>1) A big problem is affordable and accessible transport especially for people unable to drive for one reason or another. Motability Scheme is wonderful and is very valued for people who can drive or have a family member to drive for them.</p> <p>1) Gnjbuh</p> <p>2) Transport is a very expensive problem for people unable to drive especially for those with very limited mobility and without anyone to help with their transport. If taxis are their only option this can be a big burden on them financially. People dependant on paid carers for all their basic needs will only be able to afford the bare minimum of help especially if they have to pay the full cost of their care. Even if they have DLA care component at the highest rate they will struggle to afford all the help they need. So i would be very concerned if this help was cutback in any way. le to afford all the help they need. even with the help of DLA at the top rate . basics needs will be unable to afford only the m</p>
ONLINE158	<p>2) For those people who are working and use DLA as a help with travelling costs for getting to and from work. Low rate disability easily covers travel expenses inc running petrol/insurance and tax on a care every month. I am concerned that these are the people who will lose out when new reforms take place. DLA was always meant to empower people to live ordinary lives. I agree it has now become a benefit alongside IB and ESA, which is wrong and not it's original intention. Please consider where it is truly needed before cutting off a necessary 'monthly income' for those who work.</p> <p>7) There are plenty of DWP employees with disabilities. These individuals could be consulted on changes that are faced by them in the first instance, through a forum? After all these employees are the success story of working with limited good health.</p> <p>10) In some cases, the disability will be a 'mental health' one. In such circumstances, letters of support from family, doctors, work managers and other organisations, can back an individuals application for DLA. It should be up to the applicant to make a request for support.</p>
ONLINE159	<p>1) The barriers facing disabled individuals is the ignorance of minsters and governments who wrongly assume members of the disabled community are work shy. Qualifying for DLA does not automatically equate to a life on benefits. This benefit enables individuals with disabilities to part meet the added costs of living with added complications and restrictions to their independence. By implying supporting disabled individuals is unsustainable is far from embracing the "social model of disability" in fact it smacks of labelling and forcing disabled people to become 2nd class citizens and a burden to society. Additionally I think you'll find the government is actually breaching the European Law of human rights by attempting to "remodel" this benefit. They will in fact be breaching disabled people's right to independence which in itself is unlawful.</p> <p>2) Individuals who have been awarded DLA for Life or unlimited/indefinite period should not have to be reassessed for the new "PIP" benefit. If you have been awarded this benefit for an unlimited/indefinite/Life period then you will have already undergone a medical, and will have conditions that will remain with you for life such as Cerebral Palsy (David Cameron should have first hand knowledge that there is no cure for this condition) or Multiple Sclerosis. If you already have a life/unlimited award you should automatically be transferred to the "new 21st century benefit" with no reassessment. Automatic eligibility such as double amputees should also remain. Solely assessing working age recipients is also unfair if reassessment is compulsory then it should apply to all age brackets i.e. over 65 and children.</p> <p>3) Main costs include: extra heating or air conditioning costs - disabled people should be entitled to the winter fuel allowance  Help with shopping, cleaning  Going out</p>

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	<p>paying privately for services you can't access via NHS or Social Services i.e. physio</p> <p>Additional travel costs - inaccessible trains/buses means paying for taxis</p> <p>Buying additional equipment to help around the house</p> <p>Buying more expensive foods which are pre chopped or ready meals because of being unable to prepare meals</p> <p>Paying high prescription and additional medication costs</p> <p>4) Having two levels maybe sufficient if it does not result in freezing many people out who have fluctuating conditions such as Multiple Sclerosis. The two tier award should also be reflective of being able to passport to other benefits and support. For example Motability scheme should be reduced to middle rate award as should the blue badge scheme and social service awards otherwise the independence of disabled people will be further compromised.</p> <p>5) I feel if you have a lifelong condition such as cerebral palsy or pronounced disabilities such as amputees, profound blindness or developmental impairment then this should equate to automatic lifelong entitlement. In short any condition which is incurable should be automatically awarded dla.</p> <p>6) Independence is vital to any human being regardless of their physical or cognitive ability. DLA or "pip" enables independence by defining the activities that should be considered in the assessment is an insult.</p> <p>7) I don't feel that there will be any attempt to accommodate or give due consideration to individuals with fluctuating conditions such as multiple sclerosis. Because the people doing the assessments will not have the relevant knowledge to be objective. As we have already witness Atos staff are far from competent or compassionate.</p> <p>8) Again I feel this will used against the individual because if you use aids such as a wheelchair your independence is hardly going to be comparable to a fully mobile person. Having wheels does not equate to accessibility and independence as most modes of transport and buildings are still inaccessible thus aids should not be regarded in the assessment process as a marker of independence because clearly they are not.</p> <p>9) The benefit could be easier to claim if those already awarded DLA for life or unlimited period are automatically transferred to pip and not faced with the stress of reassessment. Reassessing everyone is costly, unrealistic, unsustainable and unfair.</p> <p>10) The individual with the condition and GP who will have the most constant and objective contact. Not all individuals with health conditions will be under a specialist so the GP should be sufficient.</p> <p>11) Face to face reassessment will be extremely stressful and worrying for people so again if you have been previously awarded dla for life or unlimited period then there should be no need for reassessment face to face or otherwise it should be a straight transfer.</p> <p>12) Reviews for all claimants will be again unrealistic, unsustainable and costly. So again if you have a life long condition such as cerebral palsy and been awarded DLA for life or unlimited period then there should be no need for review.</p> <p>13) By not penalising people for fluctuations in their condition.</p> <p>13) Reassurance that if things do improve that there won't be immediate withdrawal of benefit.</p> <p>?) Again, better knowledge across the board to provide seamless referral is paramount. If a two tier level is introduced into the PIP benefit then criteria to access other benefits need to be reflective of this and altered accordingly.</p> <p>?) Combining will be overlooking the individualised nature of disability.</p> <p>?) Educating all parties so there is a seamless form of signposting and referral.</p> <p>?) Funding aids and adaptations is a constant worry and unless sourced/funded via Social Services is extremely expensive. PIP should be allowed to be used in whatever way is most suited to the individual.</p> <p>?) If DLA/PIP is not acknowledged as a passport to other benefits and services then disabled people's right to independence is going to be compromised and infringed. Which will be unlawful.</p> <p>?) People need to be aware of all sources of support available such as Access to work, Homefront, Independent living funds, individualised budgets and personal health budgets.</p> <p>?) The consultation is a fast and tick box exercise. It has not be publicise extensively enough and has not attracted the media coverage and endorsement that tuition fees attracted. It has also not been a long enough consultation window and again breaches disabled peoples human rights across the UK.</p> <p>?) The whole process of reforming DLA to PIP is going to remove some peoples eligibility</p>

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	<p>to continue accessing the benefit. However genuinely vulnerable and disabled individuals should not have their right to independence compromised by a minority of individuals and over zealous government. David Cameron should be ashamed that he has endorsed such a reform given his personal insight into disability - but then disabled people and their families do not have the luxury of being able to afford care. Ultimately the government is breaching the European Laws of human rights by negating the independence of disabled people and destroying 30+ years of disabled movement and rights. David Cameron has gone back on his pre-election support of disabled people.</p> <p>?) With children the full impact of their needs will alter with development thus assessment will need to be reflective, flexible and regular.</p>
ONLINE160	<p>1) The answer to that has to be a very obvious 'their disability'. More to the point, the attitude of others. People with disabilities often require a lot more time and assistance than those who aren't disabled do. Private business' aren't often willing to meet those extra needs free of charge. Even schools fight over money before they will help some children get a basic education! You can get a wheelchair ramp or the odd visual aid but things like clubs, public facilities and even public transport don't have the time, or inclination, to offer extra help to those in need. People are selfish, it's a sad fact of life.</p> <p>2) Three levels of care. I find it absurd that the government think they can pigeon hole such a diverse range of people into just two boxes. I'm willing to bet money that those on middle rate DLA will get bumped down to lower rate PIP. It makes me wonder if this reform is simply about abolishing middle rate care - I expect it would save the government millions of pounds just by doing that.</p> <p>parents. Both children will have deficits in certain motor skill areas, but the low functioning child's can be met on the NHS whereas the high functioning child will be dependent on DLA.</p> <p>I can't speak for all disabled people, but my special needs child has extra costs for:</p> <p>Transport - to a mainstream village school as he can't manage the local town school, and to every day activities that he can't safely manage to walk to in a reasonable timeframe due to his concentration span and inability to process safety information quickly enough.</p> <p>Activities Outside the Home - because he needs to socialise in a structured way which he understands his role in. Many activities outside the home can serve as useful substitutes for those who don't qualify for state funded occupational therapy too (eg swimming, dancing, drawing, sports). I firmly believe that if I hadn't taken my son to so many activities as a pre-schooler, he would be in a special school by now and not a small mainstream one.</p> <p>Activities Inside the Home - because he lacks the natural ability to play with toys and just dismantles or lines them up if left to his own devices. He can't just be given a packet of playdoh and told to 'have fun'; he needs a packet of playdoh and several PC printouts or a colourful book of ideas to go with it, as well as adult input on how to shape and mould the playdoh to achieve the desired shapes, and put them together to create something. My son made a space alien out of playdoh when I showed him how to do it yesterday, before he just smacked the playdoh repeatedly up and down on the table while making silly noises.</p> <p>Safety Considerations - I had to carefully choose my son's furniture when I turned his toddler room into a boy's room last year. I couldn't shop to a restricted income support budget, I had to use his DLA to fund safe items which meant drawers which were low and could be attached to the walls, and a bed with a guard rail running all around it. Same goes for choosing toys, garden equipment and crockery etc.</p> <p>Clothing and Linen - these items get frequently ruined by his lack of awareness which includes ripping items outside, making his nose bleed regularly and a lack of continence awareness at times. He wears nappies at night beyond most of his peers and this means extra washing, bed padding and pyjamas too.</p> <p>Time - time is money, and that's true. My son often needs my time in the day, and robs me of sleep in the night. He takes longer to do just about everything than any other child his age I know! But I have to give him that time if I want him to be independent, and if that means we wind up eating pizza for tea some nights then I think it's a trade off that has to be made.</p> <p>Cleaning - this is quite a big extra expense for some. Sometimes it is for me, sometimes it isn't - it comes and goes. Part of allowing a disabled person to be independent means allowing a lot more mess than you'd allow from a non-disabled person before you stepped in and took over. For example a delayed child getting food everywhere needs to be</p>

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	<p>allowed to make the mess and get all the practice they can get, whereas a younger peer at that stage would just get fed. I still use baby wipes around the home for my older child and always carry wetwipes in my bag. You get through things like waterproof sheeting, vacuum cleaners, bottles of disinfectant and bleach quite quickly sometimes. You might have to pay for external cleaning services regularly or as a one-off sometimes because of soiling incidents or similar. One of the best things I bought last year was a handheld wet and dry vac as it makes me more laid back about allowing my child the freedom to make a mess and feed himself knowing I can clean it up in a few minutes when he's finished. Then of course there are all the things that get damaged as a result of behavioural problems stemming from the disability such as furniture that is climbed on, carpets that are soiled on, shoes which are tip-toe walked in and things knocked of sides and shelves from spinning and hand-flapping.</p> <p>3) It depends entirely on the disabled person in question, and this question worries me a lot. There is a lot of emphasis on paying money to those with the greatest need, but unfortunately, most people don't actually understand who those with the greatest needs really are!</p> <p>For example, a low functioning autistic child appears to have a greater need than a high functioning one. They are obviously more severely disabled, but it's the high functioning child who will make the most of any money paid out whereas the low functioning child should be able to access more direct services. For example a low functioning child may well receive occupational therapy from NHS services, whereas a high functioning child will be expected to attend public activities funded by the parents. Both children will have deficits in certain motor skill areas, but the low functioning child's can be met on the NHS whereas the high functioning child will be dependent on DLA.</p> <p>I can't speak for all disabled people, but my special needs child has extra costs for:</p> <p>Transport - to a mainstream village school as he can't manage the local town school, and to every day activities that he can't safely manage to walk to in a reasonable timeframe due to his concentration span and inability to process safety information quickly enough.</p> <p>Activities Outside the Home - because he needs to socialise in a structured way which he understands his role in. Many activities outside the home can serve as useful substitutes for those who don't qualify for state funded occupational therapy too (eg swimming, dancing, drawing, sports). I firmly believe that if I hadn't taken my son to so many activities as a pre-schooler, he would be in a special school by now and not a small mainstream one.</p> <p>Activities Inside the Home - because he lacks the natural ability to play with toys and just dismantles or lines them up if left to his own devices. He can't just be given a packet of playdoh and told to 'have fun'; he needs a packet of playdoh and several PC printouts or a colourful book of ideas to go with it, as well as adult input on how to shape and mould the playdoh to achieve the desired shapes, and put them together to create something. My son made a space alien out of playdoh when I showed him how to do it yesterday, before he just smacked the playdoh repeatedly up and down on the table while making silly noises.</p> <p>Safety Considerations - I had to carefully choose my son's furniture when I turned his toddler room into a boy's room last year. I couldn't shop to a restricted income support budget, I had to use his DLA to fund safe items which meant drawers which were low and could be attached to the walls, and a bed with a guard rail running all around it. Same goes for choosing toys, garden equipment and crockery etc.</p> <p>Clothing and Linen - these items get frequently ruined by his lack of awareness which includes ripping items outside, making his nose bleed regularly and a lack of continence awareness at times. He wears nappies at night beyond most of his peers and this means extra washing, bed padding and pyjamas too.</p> <p>Time - time is money, and that's true. My son often needs my time in the day, and robs me of sleep in the night. He takes longer to do just about everything than any other child his age I know! But I have to give him that time if I want him to be independent, and if that means we wind up eating pizza for tea some nights then I think it's a trade off that has to be made.</p> <p>Cleaning - this is quite a big extra expense for some. Sometimes it is for me, sometimes it isn't - it comes and goes. Part of allowing a disabled person to be independent means</p>

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	<p>allowing a lot more mess than you'd allow from a non-disabled person before you stepped in and took over. For example a delayed child getting food everywhere needs to be allowed to make the mess and get all the practice they can get, whereas a younger peer at that stage would just get fed. I still use baby wipes around the home for my older child and always carry wetwipes in my bag. You get through things like waterproof sheeting, vacuum cleaners, bottles of disinfectant and bleach quite quickly sometimes. You might have to pay for external cleaning services regularly or as a one-off sometimes because of soiling incidents or similar. One of the best things I bought last year was a handheld wet and dry vac as it makes me more laid back about allowing my child the freedom to make a mess and feed himself knowing I can clean it up in a few minutes when he's finished. Then of course there are all the things that get damaged as a result of behavioural problems stemming from the disability such as furniture that is climbed on, carpets that are soiled on, shoes which are tip-toe walked in and things knocked of sides and shelves from spinning and hand-flapping.</p> <p>4) As I said in my response to question two, there is no way you can fit such a diverse range of people into just two boxes. It's hard enough fitting them into three! I strongly suspect this is a cheap ploy to knock those on middle rate down to lower.</p> <p>5) Yes - including those with a physical disability, those with a serious long-term mental disability (eg autism / aspergers / bi-polar disorder) and those with a genetic condition. Perhaps this is where the low rate should really come into play - as an automatic entitlement. Too many people who should receive DLA, and really need it, don't get a penny. Perhaps those with a condition automatically entitling them to claim should get lower rate - and then apply for a higher rate in the same way someone who isn't automatically entitled applies. It'd save on a whole lot of administration in the long run and if certain conditions became known to nearly always only get lower rate, it could cut down on a lot of claims over time. If you refuse to pay DLA based on income (and I disagree with this decision strongly, especially since you say in other parts of the consultation that you want to knock money down based on aids people have!); then at least make an automatic entitlement to ensure the system is fair to all. Too many disabled people, especially children in my experience, miss out because their parents aren't able to explain themselves well enough on the forms. At the end of the day, if you have a certain condition (such as outlined above) - it goes without saying you have extra needs that need to be met one way or another.</p> <p>6) You have to have a system on the forms to ensure this is done comparatively for starters. You have to look at the life the person is trying to live, and then consider what help they need to live that life. For example with children, a child in special school will be leading a different life to a child in mainstream school. The special school child will not need to access as many out of school provisions as the mainstream child will. Similarly a disabled adult who is in a care home will have very different needs to those living independently and going out to work. DLA is NOT responsible for meeting all needs of those with disabilities, and with that in mind I welcome the introduction of the PIP. If a person is not living independently, they may require less PIP than a person living on their own does. Look at the circumstances and not just the people claiming.</p> <p>7) I think an annual automated check-up system might help, but of course that would be a case of balancing costs. People don't think to report changes a lot, but they might do more often if they received an annual reminder. With conditions that are constantly up and down, I wonder if an annual award would make more sense for some, rather than basing the award decision on a day-to-day basis. If a person's condition can't be calculated in days, then calculate it in weeks or months. Awards are rarely made for less than a year anyway.</p> <p>8) Yes, they really, really should! So much money is being wasted on some while others get nothing. Where a person's needs are being met by external services, it goes without saying they don't require cash for them. It's important that a person's whole needs are considered. For example a person who has an electric wheelchair doesn't need a high rate of PIP, but they may still require additional funding for mobility further afield (by car or taxi etc). A wheelchair or a walking aid will only take someone so far! I don't think as many people need mobility cars need them as have them. If someone with a physical disability is working full-time and cannot walk much then</p>

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	<p>of course they need one. If someone else who cannot walk much only leaves the house to go to Tesco and their GPs, then surely they could use taxis for £20 a week rather than having a mobility car?</p> <p>I think it's also important to consider things like hearing aids, prosthetic limbs and externally funded care services. If a person is having a big need already met, there is no need to pay out money which will not be used for disability purposes.</p> <p>9) There needs to be a LOT more tick boxes laid out in colour co-ordinated sections that make it easy for people to fill in (eg mobility, social skills, personal care etc). The 'how many times a day' bit needs to be scrapped, it's totally inapplicable to many disabilities and really stressful to try to fill in accurately.</p> <p>People need more pre-set choices so they better understand what it is that the money is being paid out for. In an ideal world, decision makers would all think the same way - but presently they clearly don't. What one DM grants, another one denies. More structured application forms would cut down on the lottery element that applies to the current DLA application process.</p> <p>A lot of parents with autistic children make the mistake of listing their child's behavioural problems, rather than detailing the underlying causes of the problems and explaining how funding could help them to overcome them. Unfortunately that is a lack of understanding on their part, and something the accompanying booklet needs to better explain.</p> <p>Make it clear that PIP is to help those with disabilities live mainstream lives - it's not comfort money or compensation and it isn't about grading how bad a disability is, but whether or not it can be helped with cash payments. A lot of people complain that they get no money for certain conditions, but those conditions often turn out to be things that can't actually be helped by receiving DLA - they just make the carer's feel better.</p> <p>It begs the question if carer's allowance should be based on a separate assessment though. An automatic entitlement for those receiving DLA / PIP but something that can be applied for separately. I wonder how many people who apply for DLA actually do so for the carer's element rather than the actual DLA?</p> <p>10) Reports need to be taken from multiple sources - at least three. While one report may wrongly suggest that a physically disabled person can freely move around, another two may highlight that extreme discomfort was witnessed. People are not just affected differently on different days, but they are PERCEIVED as being affected differently by different professionals.</p> <p>It's important to consider how much time the person submitting the report spends with the person in question too. It's no good asking my GP about my son for instance, she barely knows him. His school, however, see him five days a week in term time and while they are not doctors, they are able to compare my child to his immediate peer group. Similarly his paediatrician only met him twice, whereas his dance teacher seems him every week.</p> <p>There should be a mixture of reports from professionals working in different capacities. Consider the amount of time spent with the person and not just what the person's qualifications are. It's important to remember that opinions and perceptions differ drastically, and that's why there should always be at least three sources consulted in my opinion.</p> <p>I think it would be helpful to consider test results alongside the personal opinion reports, especially for mental disabilities. For example my autistic child has had a CARS assessment, a griffiths assessment and a schedule of growing skills. These tests make it easier for those who don't know my child to understand where his biggest difficulties lie, and where he needs the most help.</p> <p>11) I've heard so many horror stories about the meetings that go on with the present DLA assessments that I do not see what will change just because the name is changed to PIP. It'll be the same people doing the assessments right?</p> <p>The same people who meet with the physically disabled, don't ask to see them walk, then go back and write a report that says they can walk 400 metres with ease?</p> <p>The biggest problem with face-to-face meetings is that they are snapshot assessments that take into account how a person functions during a very short appointment in an otherwise very long life.</p> <p>Most of the current professionals seem to be general staff who don't have enough understanding of complex needs like autism. You can't understand complex conditions like autism in an hour - that's why the initial diagnostic assessments often take months.</p> <p>12) I think an annual review is reasonable, but that is providing the review is relatively informal and doesn't cause widespread panic in vulnerable people.</p>

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	<p>Fair enough to send out a tick box form and ask for an up-to-date report from a professional to validate that the person's condition has not changed during the course of the last twelve months; but if you try and make people reapply each time, or get complicated reports or deal with lots of paperwork, it'll cause widespread upset and stress to some already pretty stressed people.</p> <p>I think it's reasonable to make awards for five years at a time for those with conditions unlikely to change or improve such as young children with classic autism or down's syndrome, or those with unchanging physical impairments.</p> <p>I think it's reasonable to reassess everyone every five years, and to reassess children when they leave school too as their needs will obviously change then. They might be less by that point, they might increase with the difficulties of trying to go out to work. But either way I do think they will change at that point in their life.</p> <p>13) I think one of the best ways would be to offer a run-on payment when a change has been reported. EG continue payments for six weeks after the change has been reported perhaps. I think what a lot of people fear is that they won't be able to adjust to the loss of income when they ring up and make that phone call. If they know that it's a case of making the report, then having six weeks to adjust their finances accordingly, I think some people will be more willing to report changes.</p> <p>I also think the aforementioned annual review system would be helpful (but only if it isn't done in a stressful way!).</p> <p>?) As outlined in the consultation document, many people don't really understand what DLA is for - and so they won't understand what PIP is for either.</p> <p>I think an accompanying booklet explaining the purpose of PIP is extremely important. It's equally important to clearly explain throughout that the rate the person receives will not depend on how bad their disability is, but how much it can be helped by receiving PIP payments.</p> <p>A lot of people are wrongly denied DLA, while some people get amazing rates who don't need or have any real use for it at present. Give clear examples of what real-life people use PIP for to help claimants better understand its purpose and uses.</p> <p>?) None.</p> <p>I'm sorry but I haven't that much faith in the current system, let alone an entirely new one. Make independent, individual decisions based on original information until such a time as the service is up and running efficiently. Which in fairness will likely be never.</p> <p>How great would that be if someone wrongly got declined for one thing and suddenly found it meant they could access no help at all because of one wrong decision?!</p> <p>Data sharing about such personal matters makes me feel very uncomfortable anyway, and I'm sure a lot of disabled adults might agree.</p> <p>?) They will have developmental spurts throughout their early childhoods, and these shouldn't be considered as fluctuations in their conditions.</p> <p>They stand the most to gain from PIP in the long run, and some will go onto pay back into the system as they grow if they receive the right support early on.</p> <p>They should be assessed inline with their immediate peer group, and not a general age range. A five year old differs greatly from a six year old.</p> <p>It's important to remember that many families will have had to sacrifice their careers to care for their disabled child on income support (I really disagree with the benefit not being income related).</p> <p>Most importantly, consider the child's individual abilities and not just how they compare to their peer group over all. A child with aspergers may have some skills way ahead of his peer group, but that doesn't compensate for the areas he or she is disabled in and requires additional support to improve in. Some aspergers kids can read novels but not dress themselves, or play the piano but not be able to cross a road safely. Look at the whole child.</p> <p>?) Very.</p> <p>Wherever you go that entitles you to free entry as a carer, you can just show your DLA entitlement letter. Well, what else is there to show? In my county we have a special card that some places accept, but it's only good for a handful of places.</p> <p>What about a national carer's card? As I said above, I believe carer's should be paid separately to PIP anyway. If you don't want to link the amount of money with the severity of the disability, and rather how much it can be helped by the money, then carer's HAS to become a separate benefit. HAS TO. And it could come with a little shiny carer's card.</p> <p>Current DLA entitlements get you access to The Family Fund if you have a child with a</p>

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	<p>disability if you get middle or higher rate care.  I think things like social services are based on their own assessments though. I think.  ?) Well there kind of already are options that meet those needs, in form of the social fund and social services etc. It's hard to respond to this one.  But yes, perhaps making one-off payments in some cases would warrant a lower rate in the long run. Some people only require money for specific aids and not ongoing care after all.</p>
ONLINE161	<p>1) Access to Transport, cost of transport i.e. taxi can be expensive for those who cannot use public transport. I think only those with a registered disability i.e. sight impaired, hearing impaired etc should be considered for the benefit.  2) PIP has not been introduced so it is not possible to answer this question at this time.  3) Transport costs relating to "Mobility" As a blind person I cannot see buses coming or find a bus stop without assistance.  As a blind person cost can be incurred when dressing as colours mean nothing I would need equipment to colour co-ordinate by clothes or personnel assistance.  4) The way I see it the first section of this question is no different than the DLA system is at present.  It is possible that someone may do themselves down in order to get the higher payment. It should be based on your level of independence - what you can do not what you can't.  5) Get real who is going to tell you when or if they get better after 6 months or so - It should be based on registered disabilities. People who are terminally ill should be moved to attendance allowance with no age restrictions.  6) The problems facing the first question is that peoples abilities to cope are different. As a blind person I cannot change a light bulb but I have blind friends who can. How can you prioritise. If you are registered with your local council as a disabled person you should be assessed on that disability not on whether you can cope or not.  Transport, daily living skills and routine maintenance on your property. Assistance with shopping. Assistance with paying household bills, reading mail.  7) Keep it simple. Certain disabilities make it obvious as to what is needed.  8) It seems to me that you are complicating matters even more and you are in danger of making this a white elephant due to cost implications.  I dont believe that aids should be included this is a helping hand not a hand out.  No I dont think the assessment should take into account any aids.  9) Abandon paper and do it over the phone, hearing impaired have text phone or induction loop. The interview should last no longer than 20mins.  Radio and TV advertising and leafleting disable groups.  10) For myself my eye consultant and also my GP for health matters. Social worker can also assist with daily living assessment. My line manager could assist with my working environment.  11) I see no need for another layer of assessment when one would supply adequate evidence from a consultant, GP, social worker and or line manager.  12) This section whilst understandable is degrading to a registered disabled person in my opinion. The thought of having to go through the whole procedure again when I have already degraded myself going through it is quite sole destroying.  13) If people are made aware at award stage that penalties will be incurred if it is found that they have defrauded the benefit then there is not much else you can do but trust that basically most people are honest and they will inform the Department to any changes.  14) This is just a means of saving money and stopping peoples DLA or whatever you want to call it - nice try old trick  15) Leave people to get on with it their own way - you are becoming a nanny state  16) No I bought my own personnel aids and access to work got me the ones for my working environment.  17) No children no opinion  ?) DLA got me access to work and some council services such as wasp nest removal was half price. This is an expensive way to stop a benefit that works quite well - just be honest and say so.  ?) You agree with these statements in so far as it goes.  ?) If you want to minimise bureaucracy leave DLA alone it is adequate not perfect. Data access can be very insecure as media reports have pointed out. I would not feel safe knowing that all and sundry have access to my disability details.</p>

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ONLINE162	<p>10) My youngest son has Autism, if you are asking who is best placed to assess him then surely it is those who are continuously assessing him at the moment on a daily basis as to his abilities? This would be his teacher, his Additional Needs Assistant and his 'Spectrum Support' officer</p> <p>12) it has to be someone with a genuine understanding of how the condition affects the person concerned. I fear that 'independent' means a random stranger assigned to my sons case out of many, in order to save money, but unable to make an appropriate assessment as they have no specific knowledge, the qualification that gives that knowledge and the experience to support it.</p> <p>The person best placed would be his 'Spectrum Support' specialist in conjunction with his school additional needs assistant, they have an in depth knowledge of autism (supported by qualifications) and how it affects him whilst at the same time having a professional distance from us as parents.</p> <p>This is clearly the only way to assess properly if the assessment is designed to identify the abilities of the individual and how to support them. Any other way, particularly the faceless beurocrat makes it a pure numbers exercise to reduce claimants and therefore costs. In actual fact the 'cost' is then borne by some other segment of society, my fear is that with my sons condition he will end up unemployable if not given the support now.</p>
ONLINE163	<p>4) No we need more rates not less. You will have to put the most severly ill and disabled in the higher group thus asigning anyone with anything less to the lower group.</p> <p>This can only mean those with moderate needs will have to be lower so where do all those with low needs go?</p> <p>If you really want it to be personal and individual you need to look at the huge range of needs people have and see that having only 2 boxes to fit them in isnt going to work.</p>
ONLINE164	<p>6) For everyday life, as I understand it, participation in useful work and interaction with other people is Essential.</p> <p>Work might not just be formal employment, it may be looking after yourself and immediate surroundings - or supporting another person in so doing. People with limitations should not be ostracised for what they fail to do; rather encouraged in what they do: please keep it realistic!!!!</p>
ONLINE165	<p>1) housing providers associations</p> <p>2) Ithink there should be a grant benefit to allow garden room extensions for disable as disability facilities grant wont cover this,so you can sit out in room and also access garden</p> <p>3) petrol for disabled vehicle, also large deposits the one I want and cant have was £1600 now £3000 also autos have gone up,motability not doing there job, or greedy £95 incapacity to live on mobility money taken for car. running cost ?????????????????????? cost out of your money for food</p> <p>4) it comes across as a money saving at the end of the day, some of us rely on mobility although,we have to find £100 a month to run it</p>
ONLINE166	<p>1) People not understanding how a persons disability effects them on a day to day basis.</p> <p>2) The indefinate award for people with conditions that will last the rest of their life.</p> <p>3) Getting around as public transport is unreliable and sometimes impossible for hospital trips. Extra items needed to cope with the disability.</p> <p>4) One rate would be easier to administer and it would ensure that only the people who deserve to get the benefit will receive it. Having 2 rates will lead to more people being awarded the lower rate and still leave differences between people with the same condition and same effects on their lives.</p> <p>5) I think any condition that is for life and has a medically proven impact on the persons life should qualify automatically. Hydrocephalus or any brain injury is serious and leaves the patient with many underlying problems that are just not taken into account under the current DLA scheme.</p> <p>10) At present DLA take the information from whoever is put on the form, in my case this was my neuro surgeon who i felt was best placed to discuss the impact of my disability. However i only see him twice a year and he did not know many of the problems i had been speaking to my GP about. The applicant should provide the best account of their ability to perform certain tasks (carer in some cases)</p> <p>11) The health professional will not know the full medical background like the G.P would. Surely to have a healthcare professional see even 2 million applicants will take time and</p>

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	<p>cost more money than the benefit will save, combined with the admin and compensation for travel.</p> <p>it would be inappropriate for some people to discuss their situation with anyone other than their GP, this may lead to people not applying for the benefit as this will be seen as invasive.</p> <p>12) The reviews should be linked to medical evidence on how the illness effects people, the new benefit should have full access to medical records and carry out spot checks at random to ensure that people have reported changes, or place a flag on anyones medical record receiveing the benefit ensuring all information is passed on from the doctor.</p> <p>13) Carry out spot checks on people receiving the benefit and gain full access to medical records. Link a questionnaire to the doctor so that if the GP feels there is no need for the applicant to receive the benefit it can be stopped.</p> <p>?) * Clear information on who will qualify for the benefit and who will not, include examples.</p> <p>?) I think doctors should be better placed to inform people if they should be claiming, i was ill for 2 years before finding out what DLA was.</p>
ONLINE167	<p>1) Too many places do not consider they are disabled unfriendly if you can get in the building but if clothes etc are on rails in the store it prevent those dependent on wheelchairs from accessing the store. When I went into Nuneaton as TJ Hughjes oopened I could not get into any store including DH Evans who had to op[en] a door to let me in, then locked it again, not considering how I would leave. I have taken to shopping online. Pubs are the same and do not provide didabled facilities or if they say they do really to get to the facilities requires one to walk. Most restaurants are not disabled friendly and mt son-in-law has to put my electric wheelchair to manual, and phisically lift me and chair over the step in. The pavement into town is supposedly disabled friendly but my electric chair twisted round when I tred to use my chair to get into town so I have to get a taxi to Asda who are disabled friendly in Nuneaton. The one in Coventry has old bikes for cutomers to use and wont fit in the corridor leave alone their disabled toilet. Most disabled toilets are very small for a wheelchair to access and why do the all have really low toilet seats for disabled people who cannot easily get up from these seats?</p> <p>2) DLA was always hard to prove or get it took me three years, and in 'independent' doctor was too interested in his dinner date, to bother with me or hear me correctly due to him it took me three yearas of fighting the dhss as it was and going to a tribunal, which most people won't do, they just give up if they are turned down. If you were not in a wheelchair some did not even consider hidden disabilities. This needs to change. Only the disabled person knows the impact on their lives, and should have more say and a choice of Drs. or assesors. I was told to go to the tribunal if I had been in the wheelchair at the time I culd not have got there.</p> <p>3) I use some if my mobility for a disabled car but cannot afford to pay a driver so my son-in-law takes me if he is not too tired from work. Any product to enable one is extremely costly, holidays to facilitate the disabled are too costly one place charging £1,000 per bed not even per room but per bed so you could not have privacy anyway. So ones independence is taken as soon as you are disabled because you can no longer access places you used to. One has to go where one is taken there is no choice if the person taking you is not interested in the thingas you used to enjoy. There maybe a disabled bus but I have never had that information and can't get in to the bus station office to enquire.</p> <p>4) This sounds good but you will have to make sure it will work and not leave vulnerable people in poverty. You don't actually say what the two rates will be and if its non means tested how will you decide the level of need? It is easy for people to forget they are in fact just managing, and not doing things easily ie opening things, meals,etc using things to aid one which becomes the norm so one forgets its not.</p> <p>5) This is difficult it really helped me to have an automatic mobility allowance after a brain stem stroke, however fybromyalgia say is not so known so one does not get the help from agencies one needs and its a hidden disability who is to say who is more in need of mobility. The decision makers have to be really aware of how debilitating things like arthritus can be, even if it begun when you were in your late 50's some people get it at 25yrs. Does this rule them out of entitlement?</p> <p>6) For me it is the ability to get about my children are too scared to let me travel by train because I can't walk away from any potential danger and how do you find disabled facilities or b &amp; B's or if you do most don't have electric beds which I need as I can no longer lay flat. How do you support that? It's about not having the disabled on the fringes of society about making a law and then making it easier for the disabled to complain if the shop or</p>

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	<p>pub does not do this. At the moment its to much hassle. This requires time and a different mi nd set it wont happen overnight but laws which are seen to work have a person go round and check, either disabled or an aware able bodied person who can say "if I could not get out of my wheelchair how would I access this?" and then give them so long to comply with the law or takle them to court not relying on disabled people to complain. Since I became disabled I have noticed how badly disabled people can be treated and they don't say anything so everyone is so shocked when I say thus far and no farther because like the elderley disabled people are so used to being in the way or a nuisance that the don't say anything. Over to you.</p> <p>7) Having a regular assessment helps as long as it is not looking for away to give you less than you need. The disabled person should have someone with them who knows what they contend with even tho' it is now 'the norm'. For instance I try and be as independent as possible but have been assessed as at high risk, I'd forgotten about all the aids and instant meals,the washing every day etc etc</p> <p>8) Yes,in a word. There are many aids I would like but cant afford which would help me get strength to my legs.But can not afford it, whereas knowing I might mention this to someone and maybe get it would be a bonus. Different people need different things and what I might find useful someone else may not.</p> <p>9) I always get someone in to help me as the current form is a nightmare and again people look at the 'what else' bit and put nothing, forgetting all the aids they use and they tend to put 'how they are then' forgetting what its like when they are not so well. So all I can say is make it user friendly, little is best. No matter how clear it is some of us are not going to understand it so maybe an offer of help! Similar to the new County Council assessment where a social worker met with me a carer and my daughter, leaving her to choose a time as she is at work.</p> <p>10) I would say a hospital or your dr. whichever is appropriate and maybe supporting letters from hospital people you see to enable you more. You have to remember that a lot of people do not like to be 'labelled' as disabled..The person themselves as they know best how it affect them. But to know that a broken hip only disables you for a month wheras a stroke disables you for life. The fact of being wheelchair bound is a pointer. Come and see himm/her. Dont be in an office, not really knowing how people are affected by your decisions, but get out there and not just see but understand.</p> <p>12) Yes a very disabled person who you know will be like that for life doesnot need their nose rubbed in it. If its a temporary disability like a broken hip they should be offered help for a month say and to ask if they need it for longer. People with learning difficulties won't get better, neither will most wheelchair bound,so each case needs to be treated individually its to easy to do a one size fits all routine, when it rarely does.</p> <p>13) Often people are too busy or have short term memory loss so may just forget.I don't think people will change no matter what and of course they are frightened of their money being reduced or stopped. People with a life disability could be reassured ie I like to be independent but I am still wheelchair bound cannot open tins or jars need an implement to held me open ringpulls, cannot do housework, need an electric bed, being more independent doesn't stop me being paraplegic. If people have assesments they should pick this up then.</p> <p>?) At present you can use your dla as for a car but not all some require a one off payment,using my mobility for mobility leaves me unable to afford say the bike idea where a wheelchair is the seat and pushing the pedals stregthen your legs.some of my aids I bought, some broke after about 3years.So we already use dla if we can but with it going on a car I just could not afford it and looking at the disabled website most people find they are broke and the dwp do make it hard for you to claim what should be a right. After all we also have to deal with being disabled.P I P would be instead of dla so no choice, you have to use it to get around and for cost of living especially with VAT increases!</p> <p>?) I have never been put in touch with other agencies by DWP. It would be a good idea if, when the person is ready, and we are all different,the dla or dwp advised you of other agencies you could access. Though one does not like being pushed into a disabled only catalogue.</p> <p>?) I think it is shared, certainly I am always askediif they need to share it can they I assumed this was done by dwp too. I think a lot of disabled people would benefit from CAB advice if workers could do outreach but the Govt. would have to pay for this of course. I read a lot of things from poeple who had been denied dla and so needed CAB input. I don't understand what that's about; as even I could see they were in need.</p>

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	<p>?) I was a single parent and poor so could not 'save'. I think you should consider individuals circumstances. It is a well known fact that people tend not to save for old age and of course, until now, there has always been a pension from the state. you seem to have looked into equality quite thoroughly and that any change would not impact on one group more than another. But does this mean we will all be poorer? No one seems to be giving out any figures yet and it still scares many of us, me included.</p> <p>?) It sounds ok but what will happen in practice? We need to be told not only what the criteria is but how much. So far this govt has lied its way along so forgive my scepticism!</p> <p>?) It would be nice to be told what is available in your area tho' I found it was all at night and I can no longer cope with night time activities. I looked up UV3 but they don't operate in nuneaton. I am not into stroke clubs, so I read and watch history. We need day time activities that also include the able bodied but this costs money. It would be nice to know about disabled buses and if there are summer excursions available for wheelchair users.</p> <p>?) My child had epilepsy and I kept a diary of her fits but her consultant largely ignored me and there was no programme to help the family cope. She came in for a lot of abuse at school because she could not do all the games or swimming. She sometimes found walking difficult and as a single parent because my husband left and gave no support, emotional or monetary, so I could not afford cabs to get her to school or college, she missed 3 months of college and the exam board, would not accept epilepsy as a reason, tho' it made her too ill to walk. I actually found the dila incredibly helpful, they took onboard her differing epilepsy and how it affected her and gave her mobility. So I think each child needs to be assessed on how the disability affects them. Because my daughter had absences,full epileptic fits( grand mal) Petite mal and often she'd just be unconscious, she nearly always ended up in hospital. And children seem to be surprisingly resilient and appreciate the truth.</p> <p>My son had an asthma which affected his running and swimming.</p> <p>?) Not take action for what? This is not very clear.Whatever don't be patronising, don't treat us as if we became disabled and that meant a brain transplant, access,advice and support for.....? Some people would welcome this some would rile at being called disabled,some would not be ready to take anything else on board, it took me two years to admit I was disabled!But it would be good to know where to go for support etc .only don't house it upstairs as many agencies do.</p> <p>?) Well that would not be any different would it?</p>
ONLINE168	<p>1) Being physically impaired means that living a full and ACTIVE life takes much more effort and being perceived by others as slow is fatal at work and I found that when you develop a condition, DDA legislation is useless, because unlike 'race' legislation, there is no right of recourse to legal aid. I think the term 'disability' is misused: like the old Poor Law, I believe that there should be a 'deserving' and 'undeserving' poor; I would like therefore to see 2 classes of disability; the 1st those of us with conditions that are not 'self-induced' ie Parkinsons Disease, MS etc. and the 2nd , the 'undeserving' i.e. obesity, alcohol and smoking-related conditions, referred to in other terminology, or at least given the tag 'temporarily' disabled, rather than 'permanently'. You can guess on whom welfare benefits would be concentrated, if I were making reforms.</p> <p>3) The main cost is literally having to give up work, or work part-time....the loss runs into thousands of pounds for those of us who have had to give up 10 years before we would have retired and who would much prefer to work than stay at home...heating the house is the biggest cost, plus loss of income.</p> <p>4) The current mobility related component relates to 'walking' and being able to walk - albeit 'slowly'- disqualifies an individual from receiving that part of the DLA. Now those with Parkinsons Disease usually walk slowly, but do not qualify for mobility (as of right), which is a mistake; walking 'slowly' makes a disabled person/PD sufferer very vulnerable to being mugged, especially because they are unable to 'speed up' and avoid trouble. This vulnerability will keep them at home, rather than take that risk....I believe PD sufferers are short-changed by consequently not being eligible for the Blue-Badge parking schemes that would get them closer to city-centres and shops..</p> <p>5) Automatic entitlements would be quicker administratively .....eg Parkinsons Disease, Alzheimers etc.These do not suddenly go away; the conditions are permanent, progressive, incurable and not self-induced....it would be an insult to pontificate on their impact on a person's life....the impact I assure you, is devastating.</p>

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ONLINE169	<p>3) My son is totally dependant for all care and mobility. Extra costs are utility bills, (water, electric, gas etc.) which are astronomical. As my son is unable to move he needs to be kept warm.</p> <p>5) children (under 16) should have an automatic entitlement if they are considered within the higher bracket.</p> <p>9) Please make the form less repetitive.</p> <p>10) GP's, hospital consultants etc.</p> <p>13) Fine those who don't keep the department informed. This should be relatively easy with computers and national insurance numbers?</p> <p>? ) Children under 16 should not need to be assessed - correspondence from parents/carers, GPs and consultants should be sufficient.</p> <p>? ) In my case none whatsoever!!!!</p> <p>? ) People with severe disabilities need help not hindrance. The Government and local councils have responsibilities but most of the time shy away from them!!!! Make disabilities count!</p> <p>? ) To avoid bureaucracy and duplication - sack the local council staff who do not work in a joined up manner. No-one seems to want to take overall responsibility!!</p>
ONLINE170	<p>1) Activities for severly Mentally and disabled children/Adults are very limited. Therefore when you are accessing into the community the task becomes expensive. Generally you need assistance in the form of carers, this can mean one to two. This becomes expensive, the carers need training and finding the carer to suit the needs of the disabled person can be difficult and timely. There are not enough activities which are organised mainly by charities which seem to be having lots of cuts and there funding is not consistent to allow planning for families to organise. Many of the activities are with little notice and therefore organising transport etc adds to the anxiety to book in on these activities.</p> <p>2) The mobility component should remain for those children/Adults who access residential. They need to stay incontact with family and friends. Enjoy activities out organised by Family and friends. You are limiting there choices in a world with little activities for the Disabled person. You would be actively removing their Mobility and discriminating against them because They and their Families have chosen more structure enviroments for their loved ones to live in, as this suits there needs. You would make the lives resticting and more difficult when we as a nation and you as a government should be encouraging Mobility especially with family and friends. I believe you would be affecting there Human Right! To stay mobile when you are severly mentally and physically disabled takes carers assistance, equipment i.e wheelchairs and Cars for longer journeys to make as comfortable and efficient for all concerned. I DO HOPE THE FORM IS IMPROVED! IT IS TOO REPETITIVE AND LONG. WHEN YOU HAVE A PERSON WHO IS SERVERLY MENTALLY AND PHYSICALLY DISABLED AND THAT HAS NEVER CHANGED WHY? DO YOU HAVE TO REPEAT THE FORM (IN OUR CASE) EVERY 5 YEARS! IT IS MIND DISTROYING!</p> <p>4) Why have 2 rates if a child/adult has been classed by professional in health, social services, O.T, Physiotherapists as severly menatly and physically disabled and therefore there needs are the highest level of support needed. Those changes will not change which is always the case. Why is it not for life. The cost of assessing is expensive and so unnessary in these cases as so many professionals from birth to adult years have been involved. The process should be short and little for parents to fill in, in terms of paperwork. The forms are lenghty and are repetitive for that high dependancy disability. The system seem unfair as the checks/ form filling are the same for all levels of disability. When you have been completing forms from birth for your loved ones with little or no change and we are now going to be asked again!</p> <p>5) If a child/adult has been classed by professional in health, social services, O.T, Physiotherapists as severly menatly and physically disabled and therefore there needs are the highest level of support needed. Those changes will not change which is always the case. Why is it not for life. The cost of assessing is expensive and so unnessary in these cases as so many professionals from birth to adult years have been involved. The process should be short and little for parents to fill in, in terms of paperwork. The forms are lenghty and are repetitive for that high dependancy disability. The system seem unfair as the checks/ form filling are the same for all levels of disability. When you have been completing forms from birth for your loved ones with little or no change and we are now going to be asked again!so yes they should be automatic.</p> <p>As for needs and circumstances, this would only apply to low levels of disability.</p>

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ONLINE171	<p>1) Having to undergo medical treatment either in hospital or at home and fit it in around the other activities in their daily lives.</p> <p>2) People should be able to spend their money as they wish.</p> <p>3) Prescription costs eg for adults with Cystic Fibrosis they currently have to pay charges which is patently unfair as other medical conditions are completelt exempt. Additional travel costs eg to hospital. Medical equipment eg for CF patients treatment beds, trampolines to aid physio etc. Additional insurance costs.</p> <p>5) I think that all people with Cystic Fibrosis should at least be automatically entitled to the lower rate depending on their condition.</p> <p>8) I would be concerned if for example some-one in a wheelchair was judged as able to get around as some-one not in a wheelchair. If some-one is in a wheelchair it means that they cannot get around under their own volition, and I think this should be taken into account.</p> <p>10) GPs do not always have the full picture, ie Hospital consultants, teachers, health visitors, family members should also be consulted.</p> <p>12) Obviously the condition should be taken into account eg with Cystic Fibrosis it is likely to worsen over time, however cancer patients may go into remission.</p> <p>13) The Dept could contact individuals on a regular basis or conduct visits.</p> <p>?) Not useful to me personally as my daughter has only been awarded the Low rate despite having Cystic Fibrosis. I thikn that everyone who recieves PIP should be passported to other benefits eg Winter Fuel payments.</p> <p>?) Obviously anything above and beyond what is done for a normal child should count towards PIP.</p> <p>?) While it is all very well focusing om what disabled people CAN do, you must also take into account all the extra things that they have to do to enable them to live a 'normal' life. Eg for some-one with Cystic Fibrosis this can comprise the following: daily medication, physiotherapy, extra food supplements and enzymes, buying cooking and eating extra calories, hospital treatments etc.</p>
ONLINE172	<p>1) discrimination from employers,public and government. lack of support for those with serious needs. continual barriers put in place by departments and government and then goal posts moved, lack of support and pay for carers,lack of help and advice for disable people and their carers. continual vilification of disabled people by this and the last government.</p> <p>2) it should be provided for all disabled people not as a cost cutting exercise when you are potentially effecting many peoples lives is it worth the physical and mental cost of this ? the model as it is currently works but if it was tweaked with 1 simple thing allow the persons own medical professionals to have a say within the decision making this would enable a truer view of the claimant and enable the dwp to get rid of the main problem it has which is atos. atos is a for profit company and has no place in medical decision making where they are payed upon results IE the more we fail the more we make</p> <p>3) social mobility weather it be via motorbility, bus,taxi train. inclusion in social activities see transport. this also help many disabled people who do work carry on working if this is removed many will not be able to work therefore condemning even more into benefits and a life on bread line. Independence to live on there own and help them selfs, this could be as simple as paying extera to have shopping deliverd rather than going to supermarkets. ready meals, buying milk in smaller bottles as they cannot lift heacy weighs etc. paying to go to medical visits. being unable to take advantage of sales,promotion due to poor mobility,health, mental health therefore not getting the best bargains thus costs are increased for day to day living in all areas. not getting free medicines inherently due to the fact that they receive dla they are likely to need medication and sometime many sorts yet we have to pay job seekers and immigrants do not!</p> <p>4) usual abuse of system and mistakes will be made due to poor decission making at atos and dwp this will undoutably not change. having a 2 tier system is essentially what there is now with dla mobility only has 2 tiers care has 3 i believe. how would the people that currently get middle rate care that end up on lower rate daily living if they then find there income reduced and unable to pay for essential carers ?</p> <p>5) terminal conditions must be fast tracked without question no need for decision maker this must be done by specialist IE 1 simple form.</p>

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	<p>certain health problems should automatically be granted for certain time frames like cancers of non terminal variety as these are long time to treat and effects can last long term ms/me/cfs and many of these conditions should also be given for example 1 year at a time.</p> <p>6) peoples support should be based on many factors and many of these should be taken from statements from their own medical teams.</p> <p>varying conditions will no doubt like at the moment get thrown to the wayside dispute what has been written this happens all the time for many people and it is unlikely to change. being able to live life is the most singularly important thing for anyone being confined to your own home due to lack of support financial or otherwise is a death sentence for many people.</p> <p>respect the fact that people find it extremely embarrassing to talk about their problems sometimes particularly personal care aspects. also they may not be able to say these things or recognize in the fact that they are important ( many mental health problems will fall in to this trap)</p> <p>do not take support away from people that hide their problems well or cope well they may be coping well due to the support that they have in place through their existing dla payments, removing this would be disastrous for these people and may result in many more unemployed and an even greater drain upon medical and social services assuming that social services has not been sold off to some other company and destroyed by then.</p> <p>7) many peoples conditions fluctuate from hour to hour, day to day.</p> <p>mine for example i hurt all the time yet i try to push myself to achieve a task which for an able bodied person would be simple it can leave me wiped out for rest of the day in agony.this is where the importance of using and actually reading medical evidence from many sources physio/pain clinic gp specialist occupational therapist etc.</p> <p>simply observing someone for an hour is not enough to judge on their future and the decision can greatly help so many people if done right and destroy many people if rushed and or done purely to reach a target or goal. every person is an individual and should be treated as such each persons condition is also individual in the way that it affects them this must be looked at very closely and taken into account in a major way as many people have variable conditions.</p> <p>8) a disabled person may have an adaptation such as crutches/wheelchair to state a few of the obvious ones however take these away and underneath they still have a disability they still incur more expenses than a normal able bodied person will do.</p> <p>many conditions fluctuate (see question 7) and aids may be of no use one day or may be of utmost importance the next.</p> <p>availability of proper aids when you are on a tight budget is difficult and funding for specialized items is very difficult to obtain, some of these items run into many tens of thousands of pounds. try and save up for a power chair when your only income is benefits your care package has been reduced and everything is going up, that chair may be only chance you have at independence but if you are assessed as having that chair when you dont what good will that achieve?</p> <p>when can i expect the chair to be delivered mr dwp? answer well currently in this climate we believe that walking is better for you even though you have no legs i can do it so can you, this is how many disabled people feel about this please take note and stop kicking us when we are down.</p> <p>9) get rid of atos as their role in all benefits processes is debatable and their treatment of many people is less than honorable.</p> <p>involve the persons medical professionals</p> <p>stop changing goalposts and being target driven people with disabilities cannot help if they have these problems and do not deserve to be treated as a statistic they are a person that needs support.</p> <p>if you involve the persons medical professionals from the start fraud would be reduced dramatically,it is already incredibly low with dla as it is one of the hardest benefits to get, that way people could get the help they need faster and better targeted.</p> <p>it should be targeted at all people with disabilities of a long term nature both mental and physical.</p> <p>10) The only people that are in anyway qualified to deliver this form of supportive evidence are the persons medical care team such as gp, specialists, physios, occupational health professionals,mental health therapists etc.</p> <p>A cursory yes no answer form and a target driven interview is simply irresponsible and causes unnecessary suffering to those that need help and support.</p>

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	<p>the current software used in examinations and the attitudes of many assessment staff is that the claimant is faking it and they will do there best to detect this even if it skews there professorial duties ( shall do no harm ) by denying some people the support and help they need they cause horrendous am mounts of stress and suffering. this has not been helped by the constant vilification of disabled people by the government and the media</p> <p>11) the professional must have an understanding of the claimants condition, many examiners do not know the first thing about many of the conditions that they face in a day to day basis.</p> <p>this is where using the claimants medical team so to speak would be of great help as they know how these issues would effect the claimant. by combining this evidence it would give a much greater detailed picture than a simple face to face discussion with someone that does not know you or your condition.</p> <p>allow recording of the interviews as this will help to reduce errors and miss representation of the claiment.</p> <p>allow them to have the interview at home or somewhere local to them. in past i have had to travel up to 15 miles for dwp assessment at time i never knew about home visits.</p> <p>all staff that undertake the face to face discussion must take Hippocratic oath and undergo extensive training in the field of disability and the effects it has on the mind and body. also living as a disabled person to experience the problems faced would be a good part of this training.</p> <p>12) is there condition going to improve much within the next 12 -24 months if so then review after 1 year if not go to next question is there condition likely to improve within next 2-3 years if yes review at 24 months if not go to next question etc etc etc</p> <p>if there condition is terminal then obviously then there should be no time limit</p> <p>the reviews for different medical problems should be looked at at different times for example person missing legs and in pain regardless of weather they have wheelchair or prosthetics they still have no legs these will not just grow back so review could be spaced longer apart than the person that for example has depression or is getting help for obesity</p> <p>13) simple form to be filled in by doctor on a 6 monthly basis doctors/specialist/therapist etc to have access to specific online form to do this at dwp. that way it takes the onus away from the person and into the hands of a medical professional that understands the claimant and sees them on a more regular basis</p> <p>?) all information regarding the processes involved from start to finish including full information on how to appeal as it is likely if current trends are followed disabled people will be targeted harder and many will be found to amazingly have nothing wrong with them con-try to what they and there medical teams and obvious proof say ! again this is where statistics driven targets must be stoped and a true benefit for disabled people not just a target meeting round of cuts.</p> <p>information regarding where to get help with form filling and simplifying the questions without using trap questions.</p> <p>many people are on strong medications and struggle to find the words and ways of explaining them selfs in written form ( has taken me 4 days to formulate responses to all the questions on this consultation due to my disability and painkiller fog )</p> <p>?) dla should passport many other entitlements that should automatically be applied at the time of decision making if not then they should be included in the information sent as many benefits go unclaimed as people do not know about them or are unable to access them. particiially things like disable tax credits, help with home adoptions and help from local services.</p> <p>?) do not forget to take in to account the effect the childs disability will have on the parents/carers.</p> <p>make sure that the child and parents get all they are entitled to in the signposting including carers allowance etc some children cannot communicate same as many adults with disabilites cannot as well.</p> <p>assessments should they take place should be within the home/local hospital or an enviroment that the child knows.</p> <p>medical evidence from pediatric team should be used greatly in the decision.</p> <p>?) many people know pretty much what there is to know about there disability and know how this effects them in a day to day a lot more than anyone else.</p> <p>you must stop making presumptions about how people respond to treatments as everyone is an individual. people respond to pain in different way the same with mental disabilities each person is unique a suit one fit all approach will not work.</p>

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	<p>advise should be given to all people on all the help and support they are entitled to not them having to fight for it.</p> <p>a central point where all information for people with disabilities can get information for there local area would be a useful approach.</p> <p>if the person is trying to claim dla with no medical support then i would ask why are they calming so medical support is a must and only requirement i think for this</p> <p>?) many people use there dla for care enabling them to have a social life get to work and generally live also to help pay for one of costs like wheel chairs etc which should relay be funded centrally. if funding for saids was supplied as needed without people having to jump through hoops and fight for everything people could achieve a better standard of living as dla/pip is and will be essential in maintaining social stability living comfort and support for many disabled people.</p> <p>?) once medical evidence has been gathered and pip/dla granted it should be used by social services/hmrc/local council/schools and any other disabled services.</p> <p>information about mobility social awareness and access to social situations, care needs ,medical needs with hospitals a report to your gp would be useful inclusion with other medical services such as therapists and physios as well</p> <p>?) problem many disabled people face is the prejudiced that they are faking it this causes much distress and anxiety with disabled people.</p> <p>we have to jump through so many hoops to get the help we need dla should be a passport to many forms of help as it should encompass many areas of help such as care needs, access to adaption to home help with treatments etc</p> <p>?) stop vilifying disabled people,</p> <p>dla is one of the hardest forms of help to get by messing with it you are causing sever distress to the most vulnerable in society at the same time as esa is being rolled out and we have all seen and herd the horror stories of that fiasco which are still going on today despite government reassurances.</p> <p>pleas remember you are dealing with the weakest and most vulnerable members of this so called society, many of whom would love to be a productive person and not rely on government help not to have to tell strangers about there bowel habits or other personal problems just so they can get the help that they deserve and need.</p> <p>we are humans not many of us are scroungers and with a few simple changes ie speak to medical staff that deal with us the few fakers could be riddled out without undue stress and persecution of the people that need this financial help that dla provides the most.</p> <p>we are humans treat us like such treat us with respect and dignity something this government has forgotten to do.</p> <p>?) you need to seriously look again at removing support from people with ' lesser barriers' as as soon as this support is removed you will find that many of them will need even more support it is the current support that is enabling these people to achieve what they are</p> <p>Quote ( It is likely that some disabled people with lesser barriers to leading independent lives will receive reduced support, but this has been justified by the policy aim to focus support on those with greatest needs.)</p> <p>disability in all of its forms causes problems to treat someone with one disability more favorably than others is not the right way to go both severely disabled moderately disabled and slightly disabled all have barriers, remove any one persons support and they can easily become caught in a situation where they cannot get help as they do not have the help that they need and there physical and mental health worsens. this is a very nasty trap situation that is meant to reduce numbers not help people and is one of the worst things about this proposal.</p>
ONLINE173	<p>1) Access is the biggest barrier. That is not to say that it is stairs/steps for wheelchair users, but can be distance for walking disabled. Amenities, lack of parking spaces due to BB cheats and lack of spaces. The high costs of travel and using the car for everyday living. High costs of heating if you have circulation/mobility problems. Costs forpeople to help you with day to day shopping/cleaning some nightcare,</p> <p>2) I think the DLA is fine as it is. But there are cheats. Introduce a disability cheats line and perhaps you'll cut your budget by 50% overnight.</p> <p>3) Transport/Care/Heating/Travel (after all disabled people want to travel abroad for their holidays too).</p> <p>Clothing/access/parking/fuel/assistance/care</p> <p>4) The disabled understand the system but it seems the government doesn't. Leave it alone and just weed out the cheats.</p>

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	<p>5) Automatic. How really, can someone who isn't disabled EVER know the needs and circumstances of the individual. Having met some really idiotic 'authorities and experts' in my time, I wouldn't trust them to judge anything.</p> <p>6) Leave it to those concerned, ie the disabled to ascertain their needs and activities. We aren't stupid, we're just disabled!!!!</p> <p>7) Why not try asking the disabled person? Sometimes I'm not too bad, at others I can't move. Will someone from the government pop in every time I feel that bad? For goodness sake, live in the real (disabled) world.</p> <p>8) Consider it, but why let people who don't really know what it's like to be disabled judge what a disabled person needs. Ask the disabled person, we have brains you know.</p> <p>9) What are the criteria and provide reasons why the government is penalising the disabled to pay for their mistakes?</p> <p>10) Try asking the disabled person. Who would know better? The local vet? The greengrocer perhaps?</p> <p>11) Face to face with a 'healthcare professional' justy conjours up a self satisfied, grossly over-paid local government employee who really has no idea what it's like to deal with day to day pain and disability. Yet another obstruction to fair play. I find the very idea horrendous.</p> <p>12) Of course there should be different types of reviews. After all, who gets over polio? But many people use the old 'back pain' to cheat their way to benefits.</p> <p>13) Introduce a disabled cheats reporting line. There's plenty of them</p> <p>? Let me guess. If you're born in the UK, you will lose your dla. If you're new to the country it will be granted.</p> <p>? Penalising the disabled in a way that government dares not penalise other minority groups. Nothing short of disgraceful and brought about simply because you're too lazy and unwilling to sort the cheats from the disabled.</p> <p>? Why not? You're going to poenalise the disabled whatever the consultation process throws up.</p>
ONLINE174	<p>1) There are very different groups physically disabled and Learning disabled or a mixture of both.As a parent of a learning disabled child who I cannot see him as being able to live independently, it is important to us that he lives in a home with adults of similar age and with lots of social oppurtunities that we as parents will not be able to offer as we age. People do not understand the difficulties for the families and children with learning disabilities which grow as they become adults, there are occasions we need to accept that some cannot lead independent lives but should and can lead full enjoyable lives with support.</p> <p>2) NO The whole system needs reviewing and simplifying,</p> <p>3) For learning disabled child it is the expense caused by lack of understanding, breaking things,damage caused by impulsive actions, extra washing.the need to pay for additional person to do things with them unable to go out alone. Expense of trying to promote independence</p> <p>5) The mobility component needs to be more considerate to those who are severly learning disabled.It should be an automatic entitlement rather than the gruelling need to regurgitate the awful scenarios that you encounter with a learning disabled dependent child or adult.</p> <p>6) if you have been in a SLD school that shoiuld make you a priority, benefit should be granted and not have to be continually reapplied for, as things are not not going to be a change. Life gets increasingly more difficult, I can only speak as a parent of an SLD child who would not be able to comment for himself.I am not sure what you mean by which activities for every day life, if looking at SLD the most important thing would be to undersatnd what is going on, not any activity.</p> <p>7) Ask about fluctuations</p> <p>8) I would assume the answer is yes There needs to be a clear difference between physical adaptations and learning disabled adaptations.So far the questionnairre does exactly the same as the DLA form it is not seem to address Learning disability</p> <p>9) The form should be different for learning disability and physical disabilities completing whichever is the major problem (with a section that enables information about the other side of the problem)</p> <p>10) If you are at a Severe learning disability school that should be evidence enough.It is an</p>

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	<p>expensive exercise getting professionals to submit evidence, when you have a diagnosis of SLD not to mention the distress it causes exhasusted families to go through evry 2-3 years, when history shows once SLD always SLD.</p> <p>11) will this be a HCP that knows you or an independent practitioner and will it occur at every repeated application? Some diagnosis 's SLD do not change, though they may get worse , then there may be a need to ask for review to change rate of benefit,and it may be helpful to see someone.</p> <p>12) Absolutely SLD is evidence. Should not need reviewing unless families feel things have deteriorated,</p>
ONLINE175	<p>1) There are many degrees of disability, many people have cognitive impairment which prevents them from leading an independent life others have physical or sensory disabilities which with the right help this group may be able to lead independent lives. The barriers seem to be society itself along with inaccessible buildings, transport, toilets, and attitudes that one size fits all.</p>
ONLINE176	<p>1) The ability to be independent means different things to different people. I am a double amputee,lower limbs,and because of a hospital error I was discharged with an infection in my stump.Consequently I was unable to use a prosthetic limb until over a year after my op and the delay caused problems in my knee joint which stopped me using my prosthetic limb. I am now totally wheelchair bound but I still manage to drive a Motability car thanks to the scheme.I could never have been able to do this without my DLA. YOU NEED TO THINK LONG AND HARD BEFORE YOU START MESSING ABOUT WITH OUR LIVES.</p> <p>2) I can` t see too much of a problem with that as long as it is controlled and not abused.</p> <p>3) Personally,my car is my legs, so the cost of petrol weighs heavily on my wallet if I want the independence.</p> <p>4) What happens if a person is a borderline case between the two,who will decide which one they are eligible for?</p> <p>5) They should definitely be based on on the needs of the individual applying.</p> <p>6) Being able to wash or shower,and use a toilet. Being able to feed themselves. Being able to move in and out of their abode under their own steam.</p> <p>7) The person doing the initial assessment should have a good knowledge of the person and their problem but a regular visit by a District Nurse or other qualified person should give the appropriate cover,if there are no relatives.</p> <p>8) Yes. Personally,I purchased a Braun Chair Topper roof box because this helped to give me total independence in my car,which I considered very important.This kind of aid should be made available to help people with their independence.The only problem is NHS Wheelchairs are rather sturdy, heavy aids and can not always be used with other aids,sadly.</p> <p>9) To be honest I can` t remember as it` s quite a few years now since I applied but you must try to keep it SIMPLE!!! Not everyone is a member of Mobilise, where I found out about this document. It should be made more public,put in the National Press,not every has or can use computers.</p> <p>?) Surely,if the initial assessment is total, complete and expertly carried out, another one shouldn` t be needed unless circumstances change.</p> <p>?) All the rest of it.</p> <p>?) Not sure.</p> <p>?) Personally,DLA and Mobility have been fantastic.Even when I had my legs but was crippled with arthritis I was able to get a car and have adaptions carried out every time my situation changed, until now, I have hand controls done by Motability.</p>
ONLINE177	<p>1) needing support, especially for personal care when out, or in work. Money needed for these support need. help to do tasks that require lifting i.e. supermarket shop. Help to get to medical appointments. Its ok having the offer of electric wheelchair but i live in a road that isnt accessible using one. However i like where i live. It is easier having someone drive me in mobility car.</p> <p>2) I do think the mobility component should. I think we have come a long way with accessibility but clearly everywhere is still not accessible. Also in a family situation it is more easier for a disabled persons needs to be met by mobility car. I think changing this</p>

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	<p>also will disrupt the Motability charity.</p> <p>3) Travel, extra heating. extra costs in going anywhere purely as you have to pay for person assisting you. Food bills escalate as you have to pay for your support worker or carer. Taxis as many places it is easier to get a taxi than struggle with accessibility. Obviously there is the extra cost of paying a support worker. This is usually met depending on financial situation however its not unusual that journeys do take longer because of access problems. You may have to wait for accessible bus or taxi. If it takes longer then it will cost you more. Its not unusual for disabled people paying for support from personal money because they needed an extra few hours support as something didnt go as it should</p> <p>5) Generally it should be down to individual claims on needs and circumstances of individual however i do think there is a case for automatic entitlement of long term conditions. This usually means someone born with the disability. They spend a lifetime struggling on benefits and always need support. An idea would be a list of those conditions i.e heart conditions, cerebral palsy, Multiple sclerosis etc. A lot of support needed throughout their lives. Difficulties to sustain employment. Also these days heavy medication costs keep them as well as possible. No point medical officers putting in all this time that would collapse if we then could not have a life because of simplicities of needing to have a support worker/carer with you.</p> <p>7) This is a difficult one. A good day for me i can get around my house, a little breathless with stairs. A bad day is spent on oxygen mostly combined with bed rest. There is a risk in assessing someone you do not see the bad days. You may then decide someone is able to work but very quickly they may spiral to a lot of time off because of bad days. You have to find a way of looking at the whole picture of someone's life.</p>
ONLINE178	<p>1) Mobility issues and sometimes the inability to drive. Also for many it is the inability to earn money.</p> <p>3) It can and will vary, but it ranges from having to pay for care, to paying more for public transport (buses etc.) and paying more for food (ready meals etc.).</p> <p>5) I think there should be allowances for people who have had stroke's. Very often they will have outgoings which they must meet and have no income with which to do it. It will be much more complex assessing each individual need, but I agree that it will make the system fairer.</p> <p>6) I would say mobility is the most important thing for everyday existence and that can fairly easily be assessed.</p> <p>7) The only way is to check periodically or ask people to renew their claim every now and again.</p> <p>8) Wheelchairs should certainly be taken into account, as should other walking aids such as rotators and sticks. Any hospital should supply aids if the individual requires them. I'm not a proponent of purchasing aids on an individual basis as this very often results in people buying items which are not necessary and they get very little training.</p> <p>10) Often, information from your GP is required, whereas you may well have seen a consultant or other healthcare professional more recently.</p> <p>11) If there is a dedicated healthcare professional that comes to your house or abode, then I can't envisage a problem. It may be a major issue if an individual is expected to make their way to a health professional, as very often this is difficult or impossible.</p> <p>12) The nature or type of review should take into account the individual's circumstance. For example, some find it difficult to communicate, therefore a telephone review would be either impossible or difficult.</p> <p>13) If changes are gradual, then it is not always obvious when to report changes.</p> <p>?) Some people will find they require things such as the blue badge before they become applicable for the DLA benefit. Therefore the passport wouldn't work in this circumstance.</p>
ONLINE179	<p>1) For deaf people who use sign language to access society they are unable to join in fully. Current legislation has been ineffective and has made little impact on improving lives for deaf people. More resources/funding are needed to support the deaf community and efforts need to be made to stop/reduce discrimination and bullying of deaf people in all areas of society.</p> <p>2) The government clearly wishes to achieve cash savings of around £1.1bn by reforming the benefit. How does reforming DLA achieve this? How will renaming and benefit entitlement achieve this. DLA should stay the same but include a clear category for communication</p>

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	<p>3) DLA awarded does not meet the costs of sign language interpreters. specialist equipment needed and training to use it. improved technology but no one to help understand and use it. expensive tariffs for specialist or accessible technology</p> <p>4) majority of deaf people need a welfare rights person to help with claims. it can only be made easier if the WRO is training/knowledgeable in how deafness affects peoples lives etc. There are also not enough WRO to cope with demand and the impact of interpreting costs.</p> <p>people worry that they will lose money with the change to 2 parts</p> <p>5) being deaf and using sign language is for life and should be automatic entitlement</p> <p>6) people should be registered and issued with cards. Health professional need to be more pro active in giving advice and information.</p> <p>Being able to access information/services to meet our basic needs such as health and welfare. Able to enjoy family life/cultural identity, employment, education and leisure</p> <p>7) First conditions need to be marked permanent or not.</p> <p>If not permanent and people are registered then the DWP can contact health professionals i.e. GPs, consultants etc to see if there has been any improvements</p> <p>8) disabled people use a variety of aids, deaf people use a multitude of alerting devices in and outside the home. Government provision of aids are so out dated that they dont work well with the fast changing pace of technology i.e. minicomms . DLA when awarded should include the upkeep and replacement of these aids but when initially needed i.e. profound loss of hearing late in life then the cost of purchasing the variety of aids needed a one off cost needs to be provided upfront. Some aids need to continue to be provided by the government i.e. smoke alarms as the fire brigadeg provide and install these</p> <p>9) more Welfare Rights Officers/CAB staff/advocates/support staff to assist deaf people to apply. Social Workers should only be considered if they are specialists social workers for complex communication needs.</p> <p>If people are registered the DWP will automatically know who to contact with information so they can claim if they choose to do so.</p> <p><b>GPs DO NOT HAVE ANY KNOWLEDGE ABOUT HOW DEAFNESS AFFECTS A PERSONS LIFE ON A DAILY BASIS. RELYING ON A GP TO PROVIDE THIS INFORMATION IS WRONG.</b></p> <p>Need more public information i.e. TV screens in GPs/hospitals,public transport places,shopping centres, TV channels to include captions and BSL</p> <p>10) the person themselves (if they fully understand about DLA) with the support of welfare rights workers, specialist social workers,</p> <p>11) difficulties would be again not enough healthcare professional have knowledge about how deafness affects people on a daily basis. Hearing people 'think' that they are communicating well but in fact they do not and through lack of training are unable to identify this. many deaf people complain about the arrogance of untrained healthcare staff. Currently DWP book people with only level 2 and 3 BSL they are NOT interpreters and often cannot assist the healthcare professional appropriately. This has been witnessed on many occasions. An interpreter is someone who is level 4. DWP choose the cheapest but its the deaf person who loses out. the result is often deaf people fail the assessment resulting in appeals, time wasting and additional costs. DWP must understand/have knowledge about sign language and book the correct support. Assessors must be able to identify low life skills and be able to modify their communication to meet the clients needs, this may mean using pictures/drawings. an interpreter can only interpret the spoken word as the assessor says them, they are not allowed to say what they think the assessor means if the deaf person does not understand. Many interpreters spend too much time during the assessment 'educating' the assessor about deafness. The interpreter is not there to provide the assessor with a font of knowledge about deafness. They should already be trained/knowledgeable or ask another healthcare professional who has this knowledge to the assessment process.</p> <p>?) deaf people will never be equal. deaf people face multiple barriers/discrimination as they could also have multiple disabilities and belong to the different equality groups also. deaf people try but society holds them back</p> <p>?) set up a register and issue cards</p> <p>?) deaf people simply struggle to access other services and entitlements. Services simply refuse to make reasonable adjustments. The blue badge is now only available by telephone!!!!!!no face to face. Warm Front simply dont have the funding to enable them to provide a service to deaf people.</p>

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	<p>?) poor quality of life            ?) Yes for one off costs.            many deaf people pay out of their own pocket for interpreters as the award does not meet their needs. They are even paying for interpreters for health appointments as the NHS system for providing interpreters is appalling and ad hoc. when vital health information is needed they dont leave it to the NHS to ensure an interpreter will be there. access to health care for deaf people is abysmal.            ?) Interpreters, welfare rights officers, social workers, someone to help complete the forms</p>
ONLINE180	<p>16) people have to save up and use their current benefits to buy equipment I do not know if a one off would work</p>
ONLINE181	<p>1) Access to benefits such as DLA as recieving the proper information on claiming them.            2) The cost of stopping DLA and bringing in PIP, I feel, will be large and outweigh any benefit of this new allowance. Given the proper assessment and review process DLA would work more effeciently rather than bringing in PIP.            3) Being disabled, extra costs are accrued in general living expenses and getting around.            4) Given the complexities of differing disabilities such as physical health problems compared to mental health problems, I feel that having only two rates per component will restrict people's claims and cause more problems both for clients and administrators.            5) If someone has high needs then yes at automatic entitlement to the benefit should be awarded.            6) By providing assistance as DLA does at the moment it enables claimants to access support from agencies or support networks            7) The assessor has to be able to understand conditions and how they can fluctuate and take this into account when compiling their report.            8) I do not believe that a disabled persons aids or adaptations should be brought into consideration at the assessment process as someone continues to have a disability whether they have these adaptions or not.            9) By advertising benefits and explaining in clear language what the benefit is it would make it an easier process for someone            10) Evidence from a clients GP, physiotherapist, OT, support workers and carers should be considered when assessing their claim.            11) If information has been gathered from other professionals why does a client have to go through a potentially stressful interview with another party?            12) They should be based on case to case basis taking into consideration the persons circumstances as reviews should be.            13) By giving people adequate information and systems that enables them to report changes easily.            ?) Children's needs should be seperate from that of adults giving their development needs.            ?) Claimants should have access to independant advice and assistance to enquire and claim PIP.            ?) Disabled people require to be able to continue to lead something resemmling a normal life.            ?) Disabled people run the risk of poverty which has implications for both their physical and mental health.            ?) DLA is used for aids and adaptations and PIP has to be used for the same purposes.            ?) Individual benefits should be considered on there own merit given qualifying criteria.            ?) Support, assistance and advice is essential for this process. Claimants require support from agencies such as WRO's and advice centtres.            ?) These proposals are going to create more paperwork, more administrative work and will cost more money in the short, medium and long term.            ?) These proposals have major and wide ranging implications for disabled people and there carers and are very concerning for people.</p>
ONLINE182	<p>1) Main problem - public transport            Overcrowding - trains, busess - still not an easy option especially for wheelchair users. I depend on the freedom &amp; independence of DLA Mobility allowance Higher rate as using public transport for me is not an option. My individual disability (Progressive MS) does not allow me to stand, or walk for any length of time.            2) DLA Mobility Allowance to remain the same as it allows FREEDOM OF CHOICE for people to spend as they see fit.            Blue Badge is invaluable to the disabled population to remain an independent person</p>

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	<p>within Society.</p> <p>3) 1. TRANSPORT 2. CARE 3. EQUIPMENT</p> <p>4) Personally no - 3 rates apply to the different stages of an individual's disability. 2 rates make for complication of decisions especially for chronic &amp; progressive illnesses. 2 rates will make it far easier for a 'Private Company' focussed on cost-cutting for a Government but will only leave those individuals on the lower rate more vulnerable.</p> <p>5) Yes. Far more cost-effective for the tax-payer to have automatic entitlement for chronic/progressive illnesses as only the "Specialists" Consultants/Nurses are able to monitor conditions not "assessment" by "Private companies" whose aim is to save money.</p> <p>6) More investment in Social Services. To provide more care in Day Centres Subsidised transport for Day Centres allowing people to get out of their houses. Allowing the DLA Motorbility Scheme to remain for THE disabled people is ESSENTIAL.</p> <p>7) To pay attention to "Specialists" Consultants/Nurses. Automatic Entitlement for those conditions.</p> <p>8) No. Ridiculous. Everybody's needs vary.</p> <p>9) THE CLAIM FOR DLA SHOULD BE RELIANT ON MEDICAL EVIDENCE BEING SUBMITTED WHICH CAN THEN SIMPLIFY THE WHOLE PROCESS. DWP ONLY CONSIDERING CLAIMS WITH MEDICAL EVIDENCE. "ADVERTISING CLAIMING DLA" WILL ONLY BE CONSIDERED WITH MEDICAL EVIDENCE. REVIEW AS NECESSARY THOSE WITH SHORTER TERM ILLNESSES.</p> <p>10) Specialists in their particular field of medicine.</p> <p>11) It should not be necessary to have a 'face to face' meeting if you are already registered with a chronic, progressive illness.</p> <p>12) See question 11.</p> <p>13) the onus should be placed on the "Specialists" or GP to inform DWP of any significant changes. ?) All relevant medical history should be shared when necessary. ?) I believe DLA has allowed people if necessary, to investigate other areas of service entitlements. DWP are very helpful if you ask them. Invest in DWP instead of choosing to spend vast amounts on a "Private Health Company" . Improve DWP. ?) I understand from the proposals that children are exempt ? ?) It seems to me that the system needs improvement. However, the wholesale reform seems an extravagant waste of taxpayer funds. ?) Needs to be enforced with medical evidence. ?) People should have the freedom &amp; independence to choose how to spend their allowance to accommodate their individual needs as the current system allows. ?) See answer to question 18. ?) The proposals could quite easily discriminate individuals. As with all disabilities "one size does not fit all" ?) Vague question</p>
ONLINE183	<p>1) Traveling on UK transport system, The main problem, is of course, the lack of money to get around to lead active independent lives, Also The deaf and very hard of hearing cant lead independant lives, they are socially isolated, and cant get DLA</p> <p>2) those that were awarded the DLA, mobility and care componant, for life, should keep it for life, PROVIDING, that their circumstances stay the same, if not then reassess, the person according to their needs. As to the new criteria.</p> <p>4) there are already two rates per component, arnt there, mobility higher and lower, care higher and lower, so nobody understands this question, do you mean that the criteria for each component will change, like a deaf person can wash them selves, but cant go out alone, will may be get lower rate for care, and a blind person can go out but get the higher rate for mobility, and get a car. bit confusing this one</p> <p>11) Yes certian people should be intervied in their own homes, in fact i think all should be accessed in their own homes, It would give greater insight to the person accessing, and make it more comfortable for the person being accessed. because the LDA is so widley freeley given, it is important to make sure the right people get it, so a face to face interview in a claimants own home should be of utmost important. Anyone who did not agree to this, well, do they really need it.</p>

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ONLINE184	<p>1) mANY RECEIPIENTS WILL BENEFIT FROM OTHER ENTITLEMENTS TO BENEFITS OR SERVICES, VIA AN AWARD OF dla. THIS IS WELCOMED BUT SOMETIMES CLAIMANTS MISS OUT DUE TO IGNORANCE, OR INABILITY TO ACCESS ADVICE. THIS IS SET TO WORSEN. LEGAL HELP FOR WELFARE BENEFITS SHOULD NOT BE STOPPED AND ALL LOCAL AUTHORITIES SHOULD HAVE A DUTY TO PROVIDE BENEFIT TAKE UP SERVICES. THIS WILL IN THE LING RUN ACTUALLY HELP WITH RENT AND COUNCIL TAX COLLECTION, REDUCE COSTS ETC, ETC.</p> <p>2) Will the highest rates remain the same for special rules claimant's?</p> <p>3) There may be a whole range of assessments from differing agencies, Occupational therapy ASSESSMENTS MAY BE HELPFUL TO ASSESS A CLAIMANTS DISABILITY AND HOW IT AFFECTS THEIR NEEDS FOR DAILY HELP WITH BODILY FUNCTIONS. GP's often do not know enough about the patients disability and it's affect on their need for personal care. If this was improved it would speed up and make make claims and decisions more accurate. ESA assessments are flawed in my view, with ATOS not provididng a good quality service. This needs to be improved.</p> <p>4) The criteria would need to be looked at rather than just be a money saving exercise. Also the links between premiums on other means tested benefits may well have a detrimental affect on claimants entitlements.</p> <p>5) I deal mainly with Cancer sufferers but have no strong opinion on whether they should automatically qualify, compared to so those with enduring mental or physical health problems.</p> <p>11) Any assessments are fraught with problems, claimants do not always explain their problems clearly, there may be issues surrounding mental health, other serious illnesses, the knowledge of the HCP towards a particular condition may be limited or non existent. As assessment centres have been scaled back, home visits will take a lot of time, if done properly. This means either limiting time with each claimant or recruiting many more HCP's.</p> <p>? ) Interestingly you make no mention of means testing DLA, despite there being evidence of higher rate tax payers receiving high rates of DLA.</p> <p>? ) This would lead to enhanced poverty, the Governemnt must ensure that no one loses out as a result of a more to universal credit.</p>
ONLINE185	<p>2) that children should still be able to receive the benifit the money that she receives enables her to get the extra care she needs and enables us to attend all her hospital appointments and go to the specialist groups that she needs to</p> <p>3) the care cost and extra support and time needed to be spent with them i work part time if i worked full time my daughter would suffer</p> <p>5) yes some conditions should be exempt my daughter has downs syndrome and whilst all downs syndrome people are differnt it is well known that all people with downs syndome have some form of learning disability</p> <p>6) washing dressing etc and being able to get out and about</p> <p>7) re evaluate certain conditions every year like back problems</p> <p>9) make it not so long and stop repeating the same questions</p> <p>17) whether they have a long term condition that they are born with a disabled child will not really improve with age at all they still need their parents to be able to support them and take them to hospital appointments etc</p> <p>? ) some people would be house bound if they are unable to walk far some people reley on mobility vehicles and the blue badge scheme</p>
ONLINE186	<p>1) Physical barriers, inaccessible buildings, transport, lack of access to necessary support, ie care, in ways that are responsive and flexible. Lack of control over the necessary support. Financial considititudes,erations, ie appropriate transport for example may cost more, or the person mau have to pay costs in addition to care, like entrance fees, if they need to be accompanied to an event for example, Lack of informatiom about facilities. lack of opportunity and societal attitudes,</p> <p>2) Non means tested, freedom to spend as wished, tax free, not taken into account as income, passport to other help as appropriate. Special rules. Protection for those on the lower rate of care DLA as those claimants stand to lose,</p>

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	<p>3) The level and type of expenses varies to a degree according to specific needs, and lifestyle choices. Heating costs are higher for many, who feel the cold more easily, Electricity costs may be higher, because of use of equipment like electric chairs and beds, and also because of higher use of general household appliances to do tasks. Laundry and the need for additional baths or showers may increase water costs. equipment costs as NHs or other statutory provision may be limited or unsuitable. This applies to both specialist equipment and on modern conveniences which are needed to promote independence. Support costs if the person needs accompanying or assisting to do tasks. This is not just care costs, but but double costs like tickets or entrance for events, transport costs, and food. If the disabled person is an employer then the associated costs have to be met, Disabled people are often more reliant on public transport, including taxis. Accessible transport, whether or not the person drives themselves. Leisure costs may be higher, apart from being accompanied if necessary, facilities such as hotels, or theatre areas that offer access may charge more for these. food costs may be higher, either because the person needs a special diet, or because they need prepared, or easy prepared foods to be able to cook. Disabled people may spend more on clothing or footwear, either because they need special or higher quality items, or because wear and tear means they need replacing more often. Housing adaptation costs may also occur, the person may not qualify for help, or only get partial help under the Government scheme.</p> <p>4) The number of components will have little or no impact on understanding of the benefit, The lower component provides valuable help to those who need part time help, or meal prep assistance, this will be lost, Replacing it through statutory services will cost more. If people needing this cannot access the support there is a real risk of self neglect, or increasing disability, which will not only impact on the individual, but on their family, and on the budgets of benefit, care, and NHS provision, if reduced support means they cannot self manage,</p> <p>5) There should be automatic entitlement for those who are terminally ill. Mainly, as now it should be based on need. However consideration needs to be given to whether some automatic entitlement would be reasonable to avoid adding to the burden of certain serious conditions by way of what appears to be a detailed assessment process.</p> <p>6) Higher levels of benefit for those with the most difficulty. Targetting must, however be used carefully so that it is not a case of merely moving the goalposts, which may mean those who fail to qualify or get lower benefit are disadvantaged by lack of support. This must not be allowed to happen.</p> <p>Assessment should be based on a typical week. with the claimant asked to describe a week where they don't have adequate support, and the differences as to what they would do if they had the necessary assistance. Consideration should be given to the obvious, and less obvious consequences of not having the right support. Claimants could be asked to describe what happens if they do not have the right help. Consideration should be given to benefit for those who manage, but find it unreasonably difficult, in terms of speed, fatigue, and pain for example.</p> <p>activities that should be taken into account may vary according to lifestyle and disability but include, appearance, personal hygiene, toileting, food and drink, activities</p> <p>7) Clear questions need to be asked about frequency, and predictability of need. Asking claimants to keep a diary for a period, which may vary according to condition, can help show the pattern of needs. This can often be easier for claimants than being asked to describe their needs.</p> <p>8) Obviously if a person can use a piece of equipment without assistance or difficulty then they can be considered not to need help. However if they have difficulty, assistance to use it, or their conditions places limitations on how they use it, then only the extent to which it enhances their ability to be independent should be considered.</p> <p>There should not be a specific list of aids, the claimants situation should be looked at individually.</p> <p>As the only fair way is to consider how an aid is used. since some aids will solve one difficulty, but cause others, or place limitations, its not reasonable to make hypothetical decisions about what is suitable for someone to use. Even two people with technically the same condition may have widely varying needs and abilities in using equipment, Any attempt to 'force' people to use equipment, and then to use this to attempt to reduce or refuse benefit is unreasonable. People should be assessed according to their needs, at the time of the assessment, not based on possible solutions, which may in fact cause other problems or needs.</p>

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	<p>9) The danger of oversimplifying the form is that either claimants will not give enough information, or the right details for the correct decision to be made. If individual needs are to be assessed then it has to be sufficiently detailed to take account of different needs. It may help if claimants are given fairly detailed information as to the sort of answers that are needed, without 'leading' their answers. Some claimants may find it easier to keep a diary of needs, rather than fill in a form. If a diary was used then guidance needs to be given as to what needs to be included.</p> <p>Advisers generally are trained to advise claimants to claim if in doubt, so that a formal decision can be made about entitlement. The danger of over explaining who will qualify may mean that claimants misunderstand, and wrongly 'assess' themselves. A little knowledge can be a dangerous thing. People need to be aware of the benefit and basic information about it, but it is important that they are neither discouraged from applying or given unrealistic expectations as to entitlement.</p> <p>10) The evidence required and how this should be gathered will depend on each individual's circumstances, needs and condition. Sources could include the claimant, medical professionals, therapists, counsellors, educationalists, social workers, social care workers, or other professionals in regular contact. There is also a place for information from informal carers, or other family or friends who provide regular support. Whilst there has to be a general framework, it is important that this is an individual decision made by the DM based on the facts of the case. Only this flexibility can ensure that the correct decision is made, and claimants treated fairly.</p> <p>11) It will allow for a basic standardised approach to at least part of the process, assuming that generally the same questions will be asked. It will also allow for assessment to take account of, and ask questions about individual factors that may not be catered for, or be apparent from paperwork.</p> <p>For some claimants the process will cause undue stress which means they do not give appropriate information to allow a fair decision. The discussion will only give a snapshot view which may not cover the entirety of a person's situation. If such interviews are used it is important they are not taken in isolation, but used in conjunction with other evidence to enhance, not limit the assessment process.</p> <p>There are some claimants for whom a health professional interview may not be the best way to proceed. This could be because of the severity of the customer's condition their support needs are obvious without it. Equally for some claimants it would be unreasonable, given their condition to request they attend, because of the distress it is likely to cause. In other cases it may be that alternative evidence is more appropriate. There is a place for such interviews but in order to best serve the claimant, and the decision making process, then whether they are used should depend on the facts of the claim.</p> <p>12) Review intervals need to be set according to individual needs, and the likelihood of change, whether this is an increase or decrease in need. Award length has to be part of decision making, and as with all other parts of the decision, the DM must choose what is the best evidence to use to decide award length.</p> <p>Just as with initial claims how it is best decided will depend on the facts of the case. It may be reasonable to make less robust enquiries at the start of the review where a claimant's condition is likely to be unchanged. Further information could be sought if primary enquiries warrant it. In this situation care should be taken to ensure any worsening as well as improvements are picked up, so as not to disadvantage claimants.</p> <p>13) It is important to remember that most claimants are not benefit experts, and it is generally unreasonable to expect people to have enough knowledge to make fully informed decisions. Putting too much pressure on claimants may mean claimants unnecessarily cause themselves distress by reporting when there is no need. What can and should be done is giving customers adequate information so that they know when it is appropriate to seek advice. They should also be given details of a range of advice services. Some claimants worry and think they need to report changes after one or two better days, perpetuating the need for premature reassessment would be unfair to often vulnerable claimants.</p> <p>14) Providing information could be done in much the same way as clients are given details of possible passported entitlement when they get DLA. People may benefit from being given details of benefit and support services, from a range of sources. This might include DWP, NHS, social services, as well as relevant voluntary organisations. Signposting people gives them the opportunity to choose the best options for themselves. Advice may be less effective, people have a wide range of needs, and staff advising are unlikely to</p>

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	<p>have enough detailed knowledge of a person's situation. In addition advice and being directive goes against Governments stated aim of enabling disabled people to control their own lives.</p> <p>15) I agree with people being given information so they can make informed choices, that is good. i am totally opposed to people being 'forced' to engage with services as a condition of getting benefit. Disabilities are as individual as the people who have them. two people with the same condition may have vastly different needs. There is not and should not be a 'one size fits all approach.</p> <p>any people will have sought support over many years with no, or only limited success. It is for individuals to decide whether to seek help,</p> <p>16) Many disabled people save DLA or other benefits, often with difficulty to fund one off needs. PIP should be able to be spent as the claimant wishes, as DLA is now. If there is an option to have benefit as a lump sum, then it must be the claimants choice as to how they are paid. 'safeguards' would have to be in place to ensure that claimants are not overpaid or underpaid, if their needs change in the period covered by the lump sum. Another option may be to have a scheme for other equipment, similar to the current mobility scheme, so that items can be purchased on HP using benefits, or where appropriate, longterm leasing. As wide a range of items should be available on any such scheme, so that claimants have a true market based choice. This gives claimants another choice in purchasing large essential items. Currently those who use the motability scheme to cars or wheelchairs do not lose mobility component in hospital, or similar. This protection should continue, and be extended to cover those who use Mobility component to fund finance agreements for these items from other sources. If a scheme was started for other items, then there should be the same protection, and freedom to use other finance agreements if the claimant so chooses.</p>
ONLINE187	<p>1) there needs to be a pa register, for people who like myself with chronic ms and recieve DLA, I recieve an undividual budget and the problem of care and support arises if regular carers are of ill or holidays</p>
ONLINE188	<p>1) Peoples lack of understanding of the problems associated with any disability. Also 'lip service' that some large companies seem to have for the regulations. i.e. new (2007) local Tesco store, disabled parking about 50m away from entrance. No thought given to problems getting round a large store and then having to return to your car which is parked further away than one would like. Problems with access to public transport.</p> <p>2) No.</p> <p>3) Huge cost of running a car which if you are working or live in a rural area, is often a necessity. Heating cost, frequently all year round. Footwear, clothes, aids. Parking cost as it takes much longer to shop than an able bodied person.</p> <p>4) Two rates would appear to be the most sensible route to take.</p> <p>5) Automatic entitlement should be allowed with blind, double or single amputees (arms or legs) and possibly some chronic disabilities which will never improve.</p> <p>6) For me,my ability to do the day to day things is most important.</p> <p>7) The assessment should state that replies should be given relating to the worst days one has.</p> <p>8) Regardless of how many aids a person uses the underlying condition is still there. I sometimes use a wheelchair but am unable to self propel due to spinal problems so my carer pushes me - this should be taken into account. Having a chronic disability is, in most cases, extremely hard work, everything you do takes much longer, and requires a great deal more effort, even the simplest of things. I do not think a genuinely disabled person would reject anything that would make their day to day life easier. Assessment should only take account of aids a person is using at that time.</p> <p>9) Plain and simple english is the answer to this question.</p> <p>10) I had polio 63 years ago, my GP knows little about my disability and the problems associated with it. I see my orthopaedic consultant when severe problems occur, but apart from an occasional visit to a physiotherapist I see no other Healthcare professionals. This would make it impossible for any meaningful information to be gathered about me. There has to be an alternative option.</p> <p>10) I have serious concerns about the initial assessments.My DLA and AA were awarded to me for life. I had Polio in 1947, because, thankfully, Polio is eradicated from this country, there are very few GPs, hospital consultants, physiotherapists, occupational therapists, etc. who know anything about polio or Post Polio Syndrome. This could prove to</p>

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	<p>be a very big problem for Polio claimants and could mean that they will not receive the necessary awards.</p> <p>11) My limited experience of the majority of healthcare professionals is that after 63 years of disability I know more about it than they do! This probably applies to a lot of long term disabled.</p> <p>12) It is most important that the interviewer has medical knowledge of the claimants condition, in this way the interviewer can determine if the condition is likely to improve. However, where the claimants condition is permanent and irreversible no review should be required unless requested by the claimant because of a further deterioration in their condition.</p> <p>13) This is very difficult. I have heard of people who have asked for reassessment because of a deterioration in their condition only to be downgraded. If people are concerned about this happening they will not report any changes, be they good or bad</p> <p>14) Nowadays there is a lot of information and advice etc. on the internet and also from a wide variety of disabled groups.</p> <p>16) I pay for aids and adaptations in my home with my DLA.</p>
ONLINE189	<p>1) accessibility of transport, lack of appropriate equipment such as hoists, changing facilities etc.</p>
ONLINE190	<p>1) Financial restraint currently is one of the biggest barriers. As Local authorities remove funding that help the most disabled integrate into society and is likely to marginalise them from the big society as they become more housebound. Other barriers are attitudes and the built environment not being accessible and cumbersome procedures for enforcing accessibility.</p> <p>2) It is being said that wheelchair users will lose mobility payments as a blanket thing. This does not take into account their ability to mobilise independently in the chair or that it is the mobility payment that maintains and replaces wheelchairs nor inadequate provision through the NHS.</p> <p>3) Extra cost disabled people face are additional transport costs, help with things such as shopping, laundry, cleaning, participating in both civic and leisure activities. Help with personal care due to restrictive use of FACS Banding by local authorities and inaccurate care assessments.</p> <p>4) Two components for mobility will continue to be workable but 2 components for care will either create overpayments or will exclude people from the benefit</p> <p>5) It would enable people with certain conditions to access support in a timely manner to improve their lives or live out their remaining days with dignity</p> <p>6) The question should not be everyday life it should be to enable to participate in the Big Society. A real medical which takes into account the evidence not a series of tick boxes. Social care assessments should be used as if they exist.</p> <p>7) GP's could submit on a periodic basis a fit note type document to confirm the current state of the condition. If a condition is fluctuating getting back onto benefit at the worse times should be made easier.</p> <p>8) All as long as the success of using them is taken into account fairly. Many use aids and adaptations so that it only takes one person to assist them not 2. Proper assessments need to take place in using potential aids in order to assess usage not an arbitrary decision that this is a viable use it.</p> <p>9) It needs to be basic and then a thorough interview / medical to follow up as many current claimants for DLA undersell their needs on the claim form. Information needs to be clear, concise and available in all formats including electronically.</p> <p>10) Social Care reports and GP reports and from carers themselves</p> <p>11) If it is a true and impartial process then I see this as an improvement compared to the current decision maker process. When people are dying for instance is inappropriate and GP and Consultant evidence should be the factor that determines a claim</p> <p>12) As said before the GP should report via a note similar to fit note. Random checks should be ok. Yes they should be different types of review</p> <p>13) By advertising penalties. I know of people for instance who have lifetime awards due to osteo arthritis but have since had joint replacements but have not notified this.</p> <p>14) To be able to engage with local services that they "know and love" instead of bureaucratic national contracts. These can then steer claimants through claiming for</p>

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	<p>additional help. The PIP assesment should be portable to these other claims</p> <p>15) Setting up a beast of beuroracy has to be avoided at all costs. Signposting to agencies who can help appeal decisions or explain why decisions where made. Simpler application process will encourage more engagement.</p> <p>16) People self, fund, get them from NHS or Social Services. Get them from other people who no longer need them..</p> <p>I believe in means tests for things like aids but no a restrictive means test. In fact the whole benefit should be means tested to target those who cannot afford support.</p> <p>17) A seperate childrens assesment needs to be in place as the support they recieve in childhood can minimise the support they may need as adults</p> <p>?) It has only had usefulness in accerssing premiums for means tested benefits, blue badges and bus passes. It should be a key to accessing social care.</p> <p>?) Poverty andf lack of support</p> <p>?) The decision for ESA, DLA and Industrial Injury Benefits should be shared as the information gathered is portable</p>
ONLINE191	<p>3) General living costs - equipment for daily living; costs of carers to assist with daily living. Transport costs, especially if you have to pay fares for a carer to travel with you. Specialist equipment, e.g. specialised PCs, mobile phones, etc. Costs of visiting family or friends at a distance, or of going on holiday - may have to pay for one or two carers if going away from home. Needing to pay for an escort for ordinary outings such as to the doctors, or for pleasure, such as the theatre or cinema. Mobility equipment - wheelchairs, scooters, walking frames Cost of it taking longer to do things - may not be able to work full time if getting ready for work takes you several hours.</p> <p>5) Some people will need immediate extra help so waiting will be very bad for them and may lead to loss of morale and motivation to cope as well as they can with their disability. For example, someone who loses their sight needs help from day one, and mostly is not likely to recover. I think there should be exceptions to the waiting period for disabilities that are clearly not going to go away. help at the start can also mean someone learns to adapt and cope quickly and may then be able to move to a lower rate, or not need the benefit at all. Anyone who is in work needs help straight away, or they may lose their job due to not having the help that enables them to get back to work.</p>
ONLINE192	<p>1) My child has ME/CFS. This is a long term disabling illness. He is too sick to "Participate in society". Therefore illness (and the lack of any treatment for the disease) is the barrier.</p> <p>3) In the case of children with ME/CFS, families face extra costs because one parent, usually Mum, will have to give up work to care for and educate the sick child. Note: education authorities generally do not provide education that is suitable for children with ME/CFS. This is appalling.</p> <p>4) Two rates leads to unfairness when cut off points are defined. Quite similar individuals can end up being paid different amounts because of falling just one side or the other of the cut off point. Two components are equally awkward - what if daily difficulties are not really covered by either component? DLA works like this and it really isn't flexible enough to adequately represent peoples needs or difficulties.</p> <p>5) I think all claims should be based on the need and circumstances of the individual and that assessments should be done at home if required.</p> <p>6) The answers to this are different for adults and children. Basic essentials are toileting, washing, dressing, eating, drinking, cooking, washing clothes, cleaning, shopping, dealing with finance. Children will normally have some of this done for them, but have the additional right to access education.</p> <p>7) You can't</p> <p>8) All aids and adaption that enable a person to carry out basic everyday tasks such as eating, or shopping(as previously discussed) should be provided by government. This should include wheelchairs.</p> <p>9) The DLA form is too long and complex and subjective. It appears there are certain phrases and things that the form processors are looking for in order to tick certain boxes and grant the benefit. But you don't know what those phrases are or what they are looking for. It's like groping in the dark. The inevitable result of that is that, for example, some</p>

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	<p>people with ME/CFS will get it and some won't, according to how well they filled in the form (but not because their needs are different). That's why people get confused about what it is for and who can apply, because it is inconsistent! Sort that out and you won't have a problem with people "not being clear". Why not forget the detailed form and have every applicant assessed in person by a trained, kind and caring assessor?</p> <p>10) An expert in their medical condition, not necessarily the GP, who may lack specialised knowledge.</p> <p>11) Benefits - personal and hopefully, caring. Takes the focus off very hit-and-miss and impersonal form filling.</p> <p>Difficulties - healthcare professional needs to be exactly that, professional. We have seen many doctors and consultants who know absolutely nothing about ME/CFS so we would be distinctly unimpressed to be sent to see a person such as this. So you would incur extra training costs, and patients would often need to be seen at home.</p> <p>If a person with ME/CFS was very sick they might not have the energy to see a healthcare professional. Seeing them might be too arduous and stressful and cause their health to deteriorate. Seeing them might be possible providing the visits were very short, so more than one visit might be required. However, usually there is a primary carer who is very well versed in the condition the healthcare professional could talk to instead, with just a quick "hello" for the sick person a) to appear caring and b) to verify that they exist and all is above board.</p> <p>You would need to be flexible according to people's needs, and the system should allow this.</p> <p>12) The general nature of the disability would set the frequency of the reviews. Some don't change at all, ever, so it would be silly to review annually. For those unchanging disabilities, a simple phone call to ask how they were would do, to verify that the person still existed. For ME/CFS in children the current practice is to review every two years, and that, I think, is perfectly reasonable.</p> <p>13) Taking disabled people to court would reflect badly on the Government and cost even more tax payers money. They should repay the money they should not have had - if they cannot prove when their circumstances changed, split the difference and take a mid point since the last review date. Putting names on a website to be picked up by the local press seems quite reasonable, though I'm not sure how legal that would be!</p> <p>14) For those who are newly disabled a one stop shop covering advice on all things including benefits is sorely needed. However the quality of the advice must be exemplary - you absolutely should not force people to access advice and treatment for a condition in order to get their benefit, unless you can guarantee that the advice and treatment is going to be correct. Note that at present, much of the advice and treatment dished out to children with ME is wrong, because most doctors and consultants don't know anything about it. This has to change if you want to change the way the benefit is administered.</p> <p>15) Advice and support should be offered. It should not have to be sought out by those who are least able to do the seeking. Seeking help is one of the most psychologically demanding things to do, made all the more impossible when the help is either difficult to access or simply non-existent. The onus is on government to provide help for those members of society least able to help themselves, not to legislate to force them do the seeking for themselves.</p> <p>16) In our case, the bank of Mum and Dad funds our disabled son, with help from DLA. I do not understand your question about "an option" of using PIP to meet a one off cost. Surely, as with DLA, it is up to the disabled person to decide what they spend their money on, whether it is one off or otherwise?</p> <p>17) Generally, where adults cook, clean and wash clothes, children play. Disabled children should be no different. Whereas you might assess an adult's ability to cook, for a child you should assess their ability to play. You should also assess their ability to be educated and then provide an education that is suitable to that ability. You should not keep funding the school that the child is unable to attend, as at present. That is a crazy waste of public money.</p> <p>?) Initially a two year award of DLA gave us access to a Blue Parking Badge, which was very good. However, when we reapplied using exactly the same wording on the form (from a photocopy), we were turned down. This inconsistency is entirely normal for people with ME/CFS. It seems to depend on who processes the form and how much they know about the illness. We had to go to appeal, which left us without a Blue Badge over the summer. Although we subsequently regained our DLA, which was backdated, you can't give back a</p>

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	<p>summers worth of missed outings to a housebound child. By withdrawing the money and the badge pending appeal, you effectively judge the disabled child guilty before being proved innocent, yet we allow even our worst criminals the luxury of being innocent until proven guilty. Why do you not extend the same courtesies to our disabled children?</p> <p>?) This would mean disabled people undergoing similar assessments repeatedly to access different things. This would cost them extra effort, which might impact their health, but would at least solve the problems that arise from passporting (see Q 18).</p> <p>But repeated assessments by different Government departments is effectively "double handling" (or triple, or quadruple, or whatever). Ridiculously outdated and costly. Do one assessment and everything then cascades from that. But think carefully about the implications of the appeals procedure(see Q 18).</p> <p>?) See answer to same question in chapter 2</p> <p>?) We have not experienced assessment overlap in the way that you describe.</p>
ONLINE193	<p>?) Whilst I believe DLA can assist genuinely disabled people lead their lives by enabling them to fund support, the benefit is open to abuse. I see this as part of my job on the [REDACTED] at Warbreck House. Time and time again our customers are found to be either working in jobs that are plainly incompatible with the needs they have self-assessed or have hobbies that are incompatible e.g golfers, referees, security guards etc. Currently no questions are asked on the self-assessment regarding employment, job description and if employer has made reasonable adjustments for them. Neither are they asked for members of the household which is important as it is not unusual for another family member to give help with care needs and be in receipt of DLA themselves. A commissioner's decision has referred to this as being nonsensical (my word not theirs).</p> <p>Self-assessment is the main problem of the benefit. Of course people are going to exaggerate their needs, especially if they want a Motability car. It's human nature!! Too little evidence is obtained to substantiate their needs. Having everyone examined is a start but the examinations need to be of a much higher quality and include questions about work and life style together with a signed statement with the same declaration as the end of the claim forms.</p> <p>The provision of a Motability vehicle, whilst being helpful for the genuine customer, is also subject to many aspects of abuse. Why, when a local authority can provide transport for the customer, are they also entitled to a car? There should be a restriction on the cars available under the scheme i.e. more basic vehicles only. When our customers go in to residential care the mobility component remains payable and consequently they (their family member) can retain the car. In this particular instance the vehicle should be recalled and the money paid to the customer - this could then be used to contribute to their transport costs at the home.</p> <p>To take how DLA is payable further, in times when employment is low and people are losing their jobs, why can't it be payable through a voucher system administered through the Local Authority who could employ 'carers' who could provide the actual care needs for the customer. After all DLA should be paid by our customer to the person who is helping them with their personal care anyway.</p> <p>The types of illness that DLA is currently paid for should also be reconsidered. I am sure that the original ethos of DLA was not to pay alcoholics, some mental health problems or children with some behavioural problems.</p> <p>How Local Authorities fund their residential care homes can impact on whether DLA is payable or not. They should be stopped from using DLA to fund their obligations.</p> <p>At Warbreck House, Decision Makers are actively encouraged by management to make indefinite awards as this reduces work load by there being no renewal claims to be made. Therefore, as recently observed in the national press the customer is then not usually contacted again and as they still have their 'condition' rarely bother to notify any reduction in their abilities to cope (especially if it means losing the Motability car).</p> <p>I advise that some consultation takes place with the dedicated fraud investigation teams within Job Centre Plus for their input.</p>
ONLINE194	<p>1) This depends on the nature of the disability. My daughter has Asperger's Syndrome, a type of high functioning autism. Disabled people with no obvious outward signs of their disability have difficulty with others perception. If a person is obviously disabled, people on the whole will take the disability into account. If, in the case of my daughter, the disability is "hidden" it is very difficult for them to integrate as people can be surprised by the way they might interact and not necessarily put this down to the person being disabled.</p>

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	<p>My daughter does not know she is disabled and finds the world rather perplexing. She is 18 now, a young adult and I worry for her future as left to her own devices she would not thrive or seek help as she does not have an awareness or understanding of her own difficulties.</p> <p>3) Based on the experience of my daughter who has Asperger's syndrome the main costs are transporting her as she cannot negotiate public transport and accompanying her and / or making sure she has someone with her most of the time. In practical terms my husband and myself work part time so there is someone around while she is off college. We are not physically caring for her but she does need someone with her most of the time. This costs us in lost earnings.</p> <p>Despite being 18 and high functioning, she really needs someone with her for her safety and reassurance. As a parent this means going places with her myself or organising for a friend to go with her. This means paying for the activity for the other person or myself whereas most 18 year olds would go on their own. Petrol prices are at an all time high and add a significant extra cost.</p> <p>5) I think people with specific complex conditions such as Autism/ Asperger Syndrome should receive an automatic award. Not all people with this condition are aware of their own disability and indeed may be distressed at the thought that they are disabled. They may not seek help or be able to articulate the difficulties they have. My daughter's DLA was reduced recently I believe this happened because she does not understand fully how she differs from someone who is "normal" and what her additional needs are. There must be many other types of disability like this. Autism is a life long condition and presents many challenges to people who suffer from the condition. Because of the complex nature of the disability and that individuals may not accurately perceive their own needs, it would seem much fairer and less traumatic for the person to receive automatic entitlement.</p> <p>9) Having automatic entitlement for certain long term complex conditions such as Autistic Spectrum Disorders where the sufferer is not always fully aware of their condition or needs. This would ensure that these people receive what they are entitled to as they may struggle with the forms, both understanding the content and applying them to their own circumstances.</p> <p>11) As previously stated in previous responses, face to face may be problematic with people with complex life long conditions such as Autism.</p> <p>My daughter has been seen by numerous professionals over the years as I am sure will be the case for many autistic people. I doubt the benefit of a face to face consultation to receive the benefit, there should be ample evidence already in their medical records. I am sure these comments will apply to other medical conditions as well.</p>
ONLINE195	<p>1) As a person with M.E and severe vertigo -both hidden conditions -I have had experience with being able to walk, having to use crutches and now a wheelchair. Barriers are physical eg still inaccessible public places and other people's homes. Some shops are impossible to get into with either a wheelchair or scooter, without knocking over half the displays! Financial barriers also. DLA enables me to employ a private carer and gardener using the care and mobility parts together. It also helps to pay the extra costs needed to take taxis. Without this I would be totally dependent on friends and family to go about and this is one factor which makes you feel "disabled" and dependent. There can also be emotional barriers -people not accepting/understanding the severity of your illness or actually accepting yourself that you are disabled, but can only be enabled though having the barriers removed.</p> <p>2) DLA should still be an extra cost benefit and not dependent on NI contributions or if you have worked or not. Being able to tailor how you spend your DLA is very important as everyone has different needs and priorities. Some may choose care, transport help, to have motability, alternative therapies or new treatments. I spend a lot on attempts to get me better in the hope that one day I may get off benefits. Without the DLA I couldn't afford this. I feel strongly that people shouldn't be persuaded to have certain treatments eg CBT is one of only NHS treatments for ME and it rarely works. DLA gives a person some empowerment over treating/dealing with their own conditions.</p> <p>3) Any treatments, therapies, supplements outwith NHS. If you have a condition which has no known cause or cure you will do anything to help yourself feel better, even if it is just one symptom less. Travel, costs of mobility equipment( not all disabled people get DLA ) My main extra cost is a homehelp/cleaner. I could get personal care from council but not any cleaning, shopping etc so value being able to use DLA for this. If you have young families I</p>

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	<p>think care needs can be greater and so age of your children should be a factor?Now my children are teens they can do more,but they shouldnt be forced to through lack of finances.Also heating costs.</p> <p>4) two rates may make it easier to understand,but think three rates for care is still appropriate and should be kept.There is a big difference between needing a little care and being bedbound or terminally ill and large majority come in between.I actually think 3 rates for mobility would make it easier also!having only two rates would I think,prevent people from reporting any improvements in conditions?</p> <p>5) All claims should be based on current needs and circumstances of individuals.M.E/CFS is a good case.I am very muchmore disabled by this illness than relatives with MS,cancer.Some conditions are perceived as more serious/life threatening than others even though the individual may not necessarily need assistance/care on first diagnosis. I do think severely mentally,physically impaired claimants who have no chance of improvement should automatically qualify.</p> <p>6) personal care,treatment and therapies to deal with conditions ,equal access to public places ,communication -being able to see ,hear ,talk so you can make your needs known,being able to eat and drink,hobbies and interests which provide joy and fulfillment. Those least able to lead full and active lives may not be the most disabled?Children and those with a good support network are probably better able but thoses alone,without family and friends are most at risk.Also those who are bedbound much of the time eg many ME sufferers.I was too ill to go to hospital appointments for 7 months.No home care was given as I was too ill to even contact doctor.</p> <p>7) very difficult!medical staff need to learn more about such conditions.I suffer from ME/CFS which has fluctuated over the years,but also permanebt disabling symptoms.I think it is on account of theses stymptoms I have got DLa .I have other friends with ,ME who have struggled to "proove " how disabled they are and have not been believed by medical professionals.I think the only way is by regular diaries of condition if your condition varies?You have to put trust that people if they do get better ,will report it.I would be delighted to get off dla and be able to regain my life and health.people would report getting worse.Either that or make the payment intervals less?</p> <p>8) All aids and adaptations should be ,after all they are prescribed or bought to enable rather than disable.I would be totally bedbound without my aids and wheelchair and crutches.However they still do not make me independent or safe as I need care to use them.Prescribed aids seem to be taken more seriously but as I found,these are not generally available on NHS unless you have a serious,long term or irreversible illness/injury.Also NHS resources are standard ,so if you want something less bulky eg ,or motorised you need to finance yourself.Yes -lots of people may be eligible and culd easily obtain aids.Using DIA or PIP is a good option as that is what it is for.</p> <p>9) the form is a nightmare!While they need lots of info,there is not enough space for this,so to give a clear picture you need to fill in all other space and add extra info -not all people know that this is needed.As an ex teacher -I would suggest asking many more leading but simple questions eg explain what side effects/ difficulties you have walking.Far too complicated having to measure and time distances -this is totally impractical!Ability to download the form and complete online would be fantastic.I find writing very difficult and struggle to fillit in over 6 weeks.I do wonder if the DLa people reciving the forms really do read all the info in forms.</p> <p>10) Evidence from medical practitioners,complementary therapists,physio,occupational therapists.Howvever many health professionals will not provide any evidence,unless you are able to get recent photocopies of specialists letters.This is ok if it is something recent or indeed an illness where there is treatment ,but for ME I was diagnosed 10 years ago and there has been no successful treatment/specialist involved.Careres,homehelps also as they have daily contact,although not everyone who needs has one or can afford it.Without my DLa I coulsnd afford my private carer.</p> <p>11) Benefits - may allow a truer assessment of abilities/difficulties faced.But opposite can happen .I wa sturned down for DLa at y bvery illest when bedbound as EMP decided I was choosing to stay in bed!A face to face consultation is not always possible as a person can be too ill -although it would proove that!!If a person is mentally unwell or very physically ill this would be very stressful and could cause a relapse of illness,ebven if done at home.At anothe rlocation,the person needs to be able to travel there and this could involve long distances.Atv present I would not be able to travel to a medical as it would make me so ill that my Me would relapse even more.</p>

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	<p>12) Not sure what criteria should be used?  Yes I think that people have so many different impairments/conditions that you cant use same criteria for them all.Eg a paraplegic will be same for life,someone with arthritis may improve or worsen with treatment,someone with ME may fluctuate also,people with artificial limbs may be come more independent.It does need to be needs based - someone may be more disabled but need less help if they have a good support network of family and friends.I need less help as I have a family and friends but if didnt would need much more care.</p> <p>13) A more tolerant approach!People quite rightly come to rely on their benefits and fear how theyd manage without them.This issue applies to all benefits -it is not right that you should be better off not working than working -SO raise the minimum wage and allow people the dignity of working to better themselves!With fluctuating health conditions it is genuinely difficult to predict if small improvements will last.I was, at one point considering being eased back to work and off benefits but thankfully occupational health doctor said I was in no way fit and I needed 6 months symptom free before they would let me back.within a month I was bedbound again,so if Id told them I would have had the stress of applying all over again.People depend on sickness benefits and for many they are needed for eg increased heating bills.In the end you have to rely on the honesty of people.I know that my own conscience would not allow me to claim if I was well,but not everyone has a conscience1</p> <p>14) advice re carers,homehelps,transport ,help available.All these things I had to apply for and find out about myself.No info was given by doctors,hospital etc.Luckily I was able to but not all are well enough or able to access this info,especially if housebound.Everything is separate -blue badge,bus pass,taxi card -all need photos and separate applications.</p> <p>15) ambiguous question?Does this imply that disabled people do not wantto help themselves?Or does it mean that they are unable or uninformed of the options available?not sure how to answer this.</p> <p>16) My wheelchair and house adaptations have all been provided by NHS and council.However I would be happy to use my pip to purchase more specialised or compact wheelchair or scooter if wanted.For major alterations eg bathrooms,making house accessible I dont think this should come out of PIP.</p> <p>17) Info should be shared as there is too much repetition of assessment which is not always shared.School and hospital assessments could be very useful to submit and would provide good evidence of special needs.If care needs are being met by a school or home then pip should be appropriately reduced,just as if you are in a care home or hospital.Howver if child is being mostly cared for at home then full payments would be needed.</p>
ONLINE196	<p>1) i feel like myself i have a 4 year old with duchenne muscular distrophy n they lose the ability to do every day things as its there muscles that weaken so how can you possibly think they can live independently as possible cos as they get older they need more help as they lose there independance think you really need to read upon duchenne muscular distrophy and how it affects them x</p> <p>2) yes it all soul just stay how it is its hard to understand asit is</p> <p>5) i think some should have an automatic right to the benefit such as duchenne muscular distory as it is a progressive disease and does not get better just gets worse anything that is proven by a docor that is progressive should just be entitled to it automatically</p> <p>10) best person to ask is the persons consultant at the hospital they are under</p> <p>11) i think most health professionals are very busy people some may take the time to mett you some may not but isnt it enough from a top consultant like my child is under enough for you to go by x</p>
ONLINE197	<p>1) employers attitudes , level of disability , ability to concentrate and be alert for long stretches.</p> <p>2) the motorbility scheme</p> <p>3) alterations to home, heating/fuel costs, diet, medication, help around the home</p> <p>5) yes some health conditions should mean an automatic entilement conditions such as multiple sclerosis.</p> <p>6) by assesing the claimants ability to perform everyday tasks not only at an assesment meeting but over a period of time . The ability ot concentrate and stay alert for a full day.</p> <p>7) by ensuring that the assessors have a full understanding of the claimants condition and the effects that any medication taken may have upon them</p>

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	<p>8) aids should not be taken into account as that is exactly what they are aids they may make some situations more comfortable but is not a one size fits all answer.</p> <p>9) limit the amount of jargon and government speak making forms shorter and easier to understand. By clearly explaining exactly which conditions/criteria qualify in a clear and concise way.</p> <p>10) If a person has been treated by his/her GP then all information from that person should be made available at any meeting as should the National Health Service File held at their hospital.</p> <p>11) The difficulties are that no healthcare professional can possibly be an expert in every field. Any face to face meeting should be held in a disabled friendly location with nearby parking involving no steps/stairs.</p> <p>12) reviews should be tailored to each persons level of disability and the known likelihood of any improvement or deterioration</p> <p>13) By giving them a reasonable amount of time before any changes to entitlement are acted upon.</p> <p>14) No as this could be seen as an intrusion and a government way of targeting innocent claimants most disabled people consult their GP,hospital or specialist nurses.</p> <p>15) Most genuinely disabled people already seek advice where it is available and not been cut as is the case with multiple sclerosis specialist nurses in our area.</p> <p>16) The Motorability Scheme is an excellent one and should be continued it also depends on the cost of a one off payment not forgetting other every day costs incurred by disabled people that able people do not incur.</p> <p>17) children are vulnerable people and should not be penalised in any way or form.</p>
ONLINE198	<p>1) transport,accessibility,other peoples attitudes.</p> <p>2) If you have been awarded DLA before you reach the age of 65 you should still get after you are 65, unless you are going to replace the amount the recipient loses on attaining that age.As the disabled get older they usually need more financial help not less.</p> <p>3) Transport, heating,supplying aids in and around the house to help to stay independent, help with jobs they cant do, special diets,attending social events.</p> <p>4) Yes only having two rates should make it easier to administer, as to understanding it must be printed in a form we can understand,and those who administer the adjudication of the applications are not as arbitrary in their judgment as they are now. I cant see any disadvantages in only having two rates.</p> <p>5) there should be no automatic entitlement, except for the terminally ill, and for severely mental and physical disability. Needs and circumstances should always be the priority and not be awarded to those not in any financial need.</p> <p>6) Normal activities that able people take for granted,cooking, shopping,personal hygiene,looking after your home, going to the theater,cinema,pursuing outdoor activities with help.</p> <p>7) If by variable and fluctuating conditions you mean the person receiving the benefit, apart from very regular visits by a health visitor to check on the suitability of the person to receive the benefit, I would have thought it would be almost impossible.Or is it meant to mean the conditions of the country in its ability to pay out the benefit as we now find our selves in.</p> <p>8) No aids that a disabled person already has should be taken into consideration.I had bought and paid for my own before I even knew about DLA 14 years ago it was a struggle as I am living on state benefits. That would be penalizing somebody willing to help them selves before they receive the benefit.</p> <p>10) The GP, consultant, occupational therapist,regular carers.</p> <p>11) The benefit is in the correct healthcare professional knowing what the difficulty that the interviewee's disability causes. I cannot envisage any difficulty in a face to face meeting apart from fear on the part of the disabled person.</p> <p>12) Their GP, consultant,and occupational therapist and the person in question should be asked how their condition has deteriorated over time. Yes there should be different criteria for say somebody with arthritis and MS.</p> <p>13) By clearly stating the changes that will always need reporting either improvement or deterioration</p> <p>14) information on other agencies who could give practical help on managing their disability so maybe their need of PIP is not so great.</p> <p>15) The danger would be that older claimant or those with poor ability in understanding the</p>

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	<p>forms would give up and would slip through the net.</p> <p>16) They apply for a disabled facility grant from their local council for aids such as disabled showers, banisters for the stairs, or to their occupational therapist for toilet aids, walking sticks. If they don't receive any disabled benefits they pay for them if they can or do without.</p> <p>17) The impact that a disabled child has on the finances of the family to provide for the other children in the family</p> <p>?) I cannot see why all the relevant information should not be available to all departments who pay out any disablement benefits.</p> <p>?) the needs and circumstances should always be the priority and not be awarded to those not in any financial need.</p> <p>?) Very bad, because it is almost impossible to find out what is available for you to claim anyway if you stopped PIP as a passport to other benefits and services, at least you would be saving money.</p> <p>?) The service's I was notified about when I was granted DLA was Motability, and later on Warm front grant.</p> <p>?) The impact on the recipient who either has a reduced benefit or loosing it after reassessment after maybe receiving DLA for many years, and they are in receipt of the mobility component and use it for a motability vehicle it could in theory leave them almost destitute.</p>
ONLINE199	<p>1) The most significant obstacle for a person living with a disability is the treatment they receive from the general public. While inappropriate language is largely consigned to history, attitudes have changed less quickly. People still stare! They still talk to the person pushing the wheelchair and not to its occupant.</p> <p>For an average family, the cost of adaptations to transport and to living accommodation is extra-ordinarily expensive. The family resources are disproportionately devoted to the care of the disabled child, to the potential detriment of the other members of the family. Catching trains in London is almost impossible. Journeys must be planned days in advance. Not all buildings are accessible, though this is improving.</p> <p>2) The recognition that there are different components to the care of a disabled person should remain. The DLA is divided into care and mobility component, reflecting the nature of a person's needs. This must continue to be linked to the provision of transport (currently via Motability), though links to LA Wheelchair services could be improved.</p> <p>3) I disagree with the notion that mobility can be based on something more general than the ability to walk. A person's ability to move unaided from one place to another is fundamental to their ability to live independently.</p> <p>It may be that a person can move from one place to another using a wheelchair, or with supervision from a carer. This apparent mobility is in fact an illusion- the "mobile" person is not able to rise unaided from their bed, or use toilet facilities. Providing mechanical aids to these activities does not make a person mobile, nor does it give them the dignity of autonomy. They remain dependent.</p> <p>4) The DLA already has two components, which are largely the same as those proposed. It is entirely appropriate to distinguish between a person's mobility and the care they need.</p> <p>5) There are certain conditions which will always require significant support. Conditions such as the various Muscular Dystrophies represent a significant challenge to the sufferers and their families. Any assessment of their needs MUST be in the hands of their Doctors, and not in those of budget minded bureaucrats. The medical assessments should be carried out by the people who are specialists in the sufferer's condition, and not by a special "panel" of doctors convened simply for assessments for benefits.</p> <p>6) The person and their carers are best placed to make the decision about support priorities. This should be guided by Social Services to ensure that the person's needs are in fact being met.</p> <p>The ability to walk unaided and without supervision is the most fundamental activity. A person unable to move independently is unable to rise from their bed, wash, dress and prepare meals. They rely on carers or on mechanical support to achieve these ends. This reliance is disabling in itself.</p> <p>7) That depends on what is meant by "variable and fluctuating conditions". If this means the fluctuations in health of the person concerned, then that person's medical record will provide the evidence needed to assess needs. The assessment should not be in the hands of anyone other than the person's medical practitioner, who is best placed to understand the needs of their patient.</p>

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	<p>8) The aim of this question is not clear. What is meant by "take into account..."?  A person who is mobility-impaired needs significant support to help with their mobility and independence. If the person is already using a wheelchair which they have been forced to buy with their own money, it seems unfair that they should lose some entitlement to support.  Adaptations can also refer to work done to the family home to make it accessible. Currently financial support for such work is provided by the District Council, and not by central governmental agency. It would seem appropriate for all financial support for a person living with a disability should come from the same source.</p> <p>9) The forms are by nature complex. It would, however, make sense to hand much of the more technical responses to a medical practitioner to be completed as part of a routine consultation.  State funding for the charities which support people with disabilities is vital in supporting this. Providing family support officers to help people with completing the forms would ensure that a person's needs are being met properly.</p> <p>10) There is no substitute for medical diagnosis, and specialist doctors' teams are best placed to assess a person's ability. A disabled person should see their consultant regularly for assessment, and a part of this could be the completion of an assessment for the Personal Independence Payment.</p> <p>11) A specialist doctor, working with people with the condition that has led to the disability, is ideally placed to make judgements about ability, and to comment on the progress of a condition.  I cannot think of a circumstance where a consultation with a medical specialist would be inappropriate.</p>
ONLINE200	<p>1) Generally not enough money.  More generally, mobility is an important factor as is awareness by those who are not disabled. The cost of fuel for Motobility vehicles is also a factor.</p> <p>2) DLA should be available to anyone who fulfills the criteria to receive it irrespective of age; there should be no age related cut off.  The link to Motobility should stat the same.</p> <p>3) Fuel and other running costs for Motobility vehicles.  Household fuel expenses. Household maintenance expenses.</p> <p>4) One could foresee a lot of problems with this system; not to mention additional administration costs.  If someone were borderline between the upper and lower rates of say the mobility component, a cost issue could easily place that person on the lower part; especially by a government who were more concerned with saving money than fairness.  I think that a two tire system would be detrimental to disabled people.</p> <p>5) Yes certain conditions should mean automatic entitlement.  This does not automatically exclude the second part of the question.  Claims should also be made on grounds of need.</p> <p>6) The DLA assessment was very thorough; why not continue with that system?  The second part is a rather silly question. The essential activities for everyday life are the same as for people who are not disabled; eating, sleeping, keeping warm and dry, being able to get about are most essential. Having enough money not to worry about bills is a very important 'activity'.</p> <p>7) Ask doctors to perform regular or irregular checks.</p> <p>8) Yes aids should be taken into account; visible and otherwise.  Anything that a person needs which is extra to a non-disabled person should be included.  Some conditions will dictate that the person would require additional support later; these should be included.</p> <p>9) Forms can be simplified but not to the extent that they become meaningless. Those who need help should be offered help.  For the second part of this question, I should have thought it was not beyond the wit of DWP to work this out; then ADVERTISE!</p> <p>10) GP's and Consultants.</p> <p>11) It rather depends upon who you mean by 'a healthcare professional'?  Presently doctors are used as interviewers. I see no reason why this should change.  I see no reason not to have face to face meetings with doctors or consultants.</p> <p>12) A report from your GP and consultant/s should be involved in all reviews.</p> <p>13) DWP could have a simple form to submit annually asking for any changes.</p>

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	<p>?) Changing DLA will be detrimental for a number of people.</p> <p>?) Do not change the link with Motobility; it is hugely beneficial to me. There should also be a running cost component included.</p> <p>?) DWP could look at this during reviews; there could be other services which would be of benefit.</p> <p>?) I have nothing to offer about this.</p> <p>?) It would be a disaster if DLA/PIP payments could not be used for Motobility payments.</p> <p>?) See above.</p> <p>?) The same as now. Together with changes mentioned earlier.</p> <p>?) This could all be done by the GP with the agreement of the claimant or whoever is in loco parentis.</p> <p>?) Yes, this would be a good idea; as an addition to the basic allowance.</p>
ONLINE201	<p>1) Many of the problems are associated with the disabled persons condition rather than the public perception. For example if you have severe learning disabilities or a lifelong term mental health diagnosis, it will always be virtually impossible to lead an independent life. Not everyone can be 'cured'!</p> <p>2) I am wondering why the DLA is being scrapped rather than revisited. It is unnecessarily worrying for vulnerable people who receive this benefit who are now thinking that they will have to start again with a completely new system that will not even guarantee that they will still be eligible</p> <p>3) Transport/travel (including paying for a carers or a support workers travel expenses as well as their own; support including paying for a carers or a support workers expenses as well as their own), heating, etc.</p> <p>4) I have no idea whether this will make it easier or not - it is more about how easily accessible and how the assessment is made.</p> <p>5) Someone with a severe learning disability for example will always have a severe learning disability in which case there is no point at all in making them go through the process of assessment if it is evident that they will always be in need of support</p> <p>6) Continuing and often full time care and support is needed - preparing food, taking baths, going out, etc. Some people need 24 hour supervision to protect their safety</p> <p>7) Do not keep asking the same questions over and over again as is the way of the existing DLA forms. Just give people the chance to express themselves and the way their condition affects them</p> <p>8) Yes. Any aids should be included on an as needed basis</p> <p>9) Stop asking unnecessary and often degrading questions. Just give people a chance to explain themselves. Ensure the process is quick and simple</p> <p>10) When people have a lifelong disability there should be records (eg educational statements, etc) and there are GP's, social workers, tutors, nurses, carers, support workers, parents, etc - anyone who spends time with the person. Also it is important to listen to the person and not automatically assume that the claimant is dishonest!</p> <p>11) This might be useful in some cases but for some who are unable to socialise or mix with people it could be a very difficult time</p> <p>12) With lifelong conditions there should be no need for review - otherwise perhaps a case by case decision would be best</p> <p>13) It needs to be understood that many who qualify for this payment cannot manage their own affairs and have difficulty managing their own lives at all - to remember to notify a particular department of any changes might be very difficult. In the case of mental ill health, often people don't even realise that there have been changes!</p> <p>?) Clear and simple and easy to understand without jargon</p> <p>?) Don't know the answer to this</p> <p>?) I would have hoped that the current system is already inclusive</p> <p>?) In our experience they fund their own in the main and it would be useful to have a one off cost system</p> <p>?) It means more work, a more disjointed system instead of an holistic smooth system</p> <p>?) It would be difficult to require people to take advice and support</p> <p>?) Surely there is no reason not to combine all manner of assessments? For example, Direct Payments and ILF could be done as one - the fewer assessments the less impact on someone's life and mental well being</p> <p>?) The children will likely have educational statements that can be referred to. Also parents should be consulted</p>

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	?) The thought of these changes quite frankly fills me with dread and I am a professional - so how will the impact be for those vulnerable people who will be affected by this? Why not simply improve what we already have instead of reinventing the whole system??
ONLINE202	<p>1) The barriers are relative to the persons disability and not created by society. Society caters for disabled people well and integration is not a problem unless the disabled person is inconveniently placed, that is they are in a position not suited to them or trying to do tasks their disability does not allow them to accomplish.</p> <p>2) The Disability Living Allowance is an essential and working system. The system should be modernised only to asses everyone medically from both GP s and hospital clinicians and other staff caring for disabled people.</p> <p>3) Mobility costs are the most expensive costs. This is well covered by the Motability scheme. Costs relative to the persons ill health such as extra housing requirements heating and dietary needs. Cleaning and medical equipment are also expensive.</p> <p>4) The current system is easy to understand. Its the complexity and repetition of the questions on forms that are confusing. Having less levels of any benefit with make it more difficult to categorise individuals disability.</p> <p>5) All disability's should be treated individually. However assessing people who have already submitted substantial support from medical clinicians, doctors and general practitioners seems wasteful and presents a problem of clashing with lesser informed healthcare professionals conducting the assessment. This leaves the disabled person trying to explain complex and difficult scenarios to the healthcare assessor.</p> <p>6) Mobility needs are the primary activities, well provided for under DLA through the Motability scheme this should be given priority. Enough money for the purchase of additional medical equipment and any breathing aids the person should require.</p> <p>7) Ask the person, no one knows more about a persons disability or ability that the person themselves. Ask the healthcare professionals such as doctors, general practitioners, physiotherapists and dieticians that all contribute to helping the persons disability to a manageable state. Ask the persons carer of the other people that spend time managing and assisting the disability.</p> <p>8) No. Disability is irrelevant to aids medication, or assistance. How the person manages t,heir disability is no one else's business.</p> <p>9) Making the experience easier for the person is a matter of listening to those that have helped support the claim. By assessing supporting letters for General practitioners, nurses, physiotherapists and any other official medical support, many of the questions can be answered and this does not leave the disabled person with the burden of trying to convince a healthcare assessor who most likely will not fully understand the condition.</p> <p>10) Official doctors and medical staff should give support to any claim. Hospital clinics, General practitioners and support staff are all trained and understand the persons disability far in excess of the assessor and in some cases Carers.</p>
ONLINE203	<p>3) rent or mortgage if disability is due to accident, travelling expense, paying for food when attending hospital and expense of family travelling with you to appointments.</p> <p>5) I personally believe that anyone diagnosed with Cancer and going through treatment ie: Chemotherapy and radiotherapy should automatically be entitled to benefit. I have personal experience of this and i was treated terribly by DWP and was not given any extra help during or after my cancer treatment i actually appealed and felt like a liar. I still never got any benefit.</p> <p>10) I feel that getting reports from GPs should not be used as the GP does not see or hear from any patient after they have referred them to hospital surgeons etc. The reports should be obtained from the specialist who deals with the patient through surgery or aftercare at hospital.</p>
ONLINE204	<p>1) 1. Physical and practical barriers, despite legislation, kerbs, steps, websites that don't work with access software and so on</p> <p>2. Inflexible work - full time or nothing is still very prevalent</p> <p>3. A culture that encourages competition rather than compassion</p> <p>4. Lack of education in schools about the contribution that disabled people can make</p> <p>5. Poverty</p> <p>?) Sorry, too tired to answer any more questions now!</p> <p>3) Where to start? Having to pay people to do things that able bodied people can do themselves. Having to heat our houses more as we may be there more often, may not be able to move around so much, may have sensitivity to cold. Having to take taxis very short</p>

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	<p>distances. Having to buy ready prepared food instead of cooking from scratch. Aids and adaptations. This questions seems very general, given that blind people's needs will be very different from amputees' for example.</p> <p>4) I don't think lack of understanding is the problem. Two rates or three rates will not make a significant difference to anyone's understanding. I cannot comment on the ease of administration. To me the problem with DLA has always been a crass lack of understanding of disability reflected in the questions asked and the inconsistent decisions. I don't see these new proposals improving this.</p> <p>5) Depends what you mean by Circumstances. Do you mean that someone needing kidney dialysis could be refused benefit because you decide that someone in his / her family can somehow provide? I'd say that some conditions will always entail extra costs and should bring an automatic entitlement.</p> <p>6) I am concerned about this emphasis on the least able. It feels like a competition between very disabled and very very disabled. I feel it should be more to do with being unable to lead a full and active life, not being that bit more unable than someone who is also unable! All disabled people know that there is someone worse off than ourselves, but that does not mean that we have no needs. So I'd say you do not need to prioritise, you need to set a line beyond which needs are recognised.</p> <p>I think there's a general agreement that we all need to be connected with other people (social activities) to contribute to society (paid or unpaid work opportunities) to experience nature (going out into the natural world) to see our families and, for some of us, spiritual community / religious worship is essential too. As much independence as possible in taking care of our own needs in terms of food provision and so on seems pretty essential to me too.</p> <p>I think these things are not only essential to the disabled individual but also essential to a healthy and compassionate society</p> <p>8) The assessment already takes into account aids and adaptations, for example callipers, walking aids and so on. To include wheelchairs is a step too far I think. Rolling and walking are not equally easy activities, or equally doable in all situations. Using a computer with access technology is far more tiring and slow than using one without. Aids and adaptations are great but they do not usually remove all barriers and I am alarmed at the suggestion that they do. I would strongly disagree that if someone has acquired a wheelchair they are now able bodied and face no barriers or difficulties or extra costs.</p> <p>I am also wary of the idea that we can easily obtain aids and adaptations that we are eligible for! Speak to anyone requiring heavy duty orthotic footwear for example (as polio people like myself often do) and you are unlikely to find any that are able to rely on the very limited NHS offerings. I'd say in principle it is always wrong to deduct entitlement on the abstract idea that someone could receive something, rather than the reality that they have done so.</p> <p>9) It isn't just the form, it's the assumptions it is based on. For example the current DLA form specifically excludes difficulty in walking on uneven surfaces, so the walking section is always going to be difficult to fill in if you are in that situation as none of the available answers will describe the person's real life situation. It is the knowledge, expertise and, above all, true intentions behind the form that are the crucial issue.</p> <p>Improving information - well, you seem to be cutting down on public information at the moment so I'm not sure I understand this question. Personally I think you could try making it clear that you wish to save money on the disability benefit bill and exclude as many people as you can get away with, while encouraging divisiveness amongst the disability community and an atmosphere of fear and hatred of disability from people who are currently able bodied . . . .</p> <p>10) I'd like the professionals involved to read up on the condition they are dealing with before they start questioning us. You might be surprised how rarely this happens in the case of uncommon conditions. My heart sinks at the idea of facing yet another medical professional who hasn't covered my condition in medical school and is full of bizarre and inaccurate assumptions.</p> <p>Also, for those of us with conditions for which there is no drug or other treatment, we often don't have much of a relationship with many medical professionals. There is no point going along and telling your GP or neurophysiologist that you still have muscle weakness and profound fatigue if there is nothing they can do about it. The lack of recent appointments is then often used against us. So I'd be wary of too much emphasis on a GP's or consultants' report for some conditions.</p>

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	<p>I understand that we're all individuals with different levels of disability, even within the same condition, but my biggest frustration is the failure to accept that for some people, some damage is documented and irreversible and doesn't need to be constantly disputed or reassessed</p> <p>11) see the above answer</p> <p>12) Yes I think it's pointless to check whether an amputee is still an amputee, and so on. I appreciate they may have differing needs but the limb won't grow back. I'd say a list of irreversible and progressive conditions would be a good starting point. And, again, I have misgivings about the quality and intentions of these reviews - see above</p> <p>13) You will need to realise that some people will be unable to do this, for example those with some mental health problems or learning difficulties. And you also need to understand fluctuating and variable conditions. I'd also suggest that equal weight is given to inviting people tell you when they have more needs as well as less</p> <p>14) Good clear information on, say, NHS aids and adaptations sounds helpful enough but I doubt that the dwp is best placed to advise on all forms of support. Making benefit dependent on exploring inappropriate "support" fills me with horror. Does para 36 suggest that you might consider a motability car as a one-off cost rather than an ongoing one?</p> <p>I understand that you don't want the government to be double-funding anything but I'm not sure how much of a problem this is. I suppose I do buy things from my DLA that other government agencies could theoretically supply but the reality is very different to that theoretical situation.</p> <p>15) No, I don't think requiring anyone to "access advice and support" is likely to be helpful.</p> <p>16) Possibly, but this rests on the premise that some disabilities can be eliminated by one item being provided, which I don't think is realistic. If you need, say, a wheelchair, I think it's unlikely that this will be the extent of your needs. It's true that large items can be helpful but I think most of us currently save for these out of our DLA.</p>
ONLINE205	<p>1) too many people using disabled parking places that dont use wheelchairs or scooters who appear to walk easily and long distanses</p> <p>2) we need more help with insurances and other costly things</p> <p>3) travel including insurance</p> <p>4) who decides who gets what and people who are not used to filling forms will loose out</p> <p>5) needs</p> <p>8) yes</p> <p>11) you must get it right</p>
ONLINE206	<p>8) in the case of hearing aids should they be included when some people use them having been brought up that way to use them and some do not either becuase of choice (maybe from culturally Deaf families) or are not useful for them. at the end of the daythe communication issues are still the same we all struggle to have a full understanding of the world around us whether we use aids or not so i don't think this is a fair way to judge people</p> <p>11) for deaf people having a assessment is not a true reflection of everyday life...in a quiet room with the doctor/assessor aware of the disability well lit room and able to position yourself for maximum understanding may give the assessor a `false` understanding especially for thoses who first language is not nessacary sign language but rather speak in which case even if they are profoundly deaf with good speech and language skills could make them appear `less disabled than actually are</p>
ONLINE207	<p>1) disabled people have many different problems / barriers preventing them from participating in society and leading independent lives. This is not easily quantifiable as different illness causes different problems. My own problems are - medication stops a driving licence - bus stop to far to walk to as 10yds is limit apx - rural location no local taxi - rely on friends or long distance taxi - last one was £46 as needed to get home as so unwell.</p> <p>Mobility scooter is my independence within the village or I would be housebound -I required a new scooter this year if purchased through route to mobility it would have been 6250 and not been mine after 3 years or buy outright for 3950 - my elderly father purchased it for me and I pay him 120 per month. It should be looked into the cost of these appliances as it is a market that is exploiting disabled you do not purchase these if you do not need them.</p>

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	<p>Personal care even if could afford it as often as needed it would not be easily attained - therefore I struggle and take 2hrs to shower, go around with no sox on employ a cleaner as it is important to have a clean house and eat more than microwaveable meals.</p> <p>2) It should not only be terminally ill that are fast tracked, when people have debilitating illnesses they need it dealt with quickly - it took a long time for my diagnosis to come round and i initaly got dla for 18 mths then open ended. I would have been happy to be assessed every 6 mths for the first two years if it meant the process had been quicker. When you are this ill and your world is crashing around you, you need all the support that you can get. - I also realise that there are people who work the system but surely they are a minority and why should genuinely ill people be penalised for the few.</p> <p>3) Travel, support, personal care, home care, it is the little things that you do not think of i.e. easier food packing to open , reasonable quality ready meals, shower gels that can open and squeeze etc. weight of a Hoover, chairs to get out of easily, going to a low cost furniture store is not an option when you can not get out a chair without extreme effort.</p> <p>5) If these health conditions have a severe effect on your ability to live independantly they could be automatic entitlement i.e. paralysis from neck down. However if the conditions have a variety of stages or different levels they should not be automatic. i.e. autism. I do think though that if they do not have an automatic entitlement to them there could possibly be a second stage of highlighted illnesses that could be fast tracked for assessment.</p> <p>6) Social inclusion and dignity</p> <p>7) This I do not know, today I can get my sox on yesterday I could not and had cold feet all day tomorrow who knows if I will get the sox on or not - what I do know is that it will still take me 2 hours to shower and I wont be able to get beyond the front gate by walking and the level of pain will be unbearable as always.</p> <p>There needs to be a system that that if you are assessed on a good day ! it can take account of the bad days be it written evidence from occ health, doctor, nurse, carer, family member - i try to avoid doctors although i feel i keep the NHS in a job the amount of visits to different departments - i visit my gp - i visit the nurse but not one of them has the holistic picture but may be my medical notes do and i would have no problem with these being accessed.</p> <p>8) Yes they should be taken into account, but it should also be taken into account how these aids are paid for - as I previously stated my main independence comes from my mobility buggy - i pay for this through my DLA - if I was assessed I did not need DLA because I had the mobilty buggy how could i replace it when it was finished - also i need to get taxis</p> <p>I have aids in the house - I have a walk in shower that my family paid for, i have grab rails, i have a heating system that my family paid for. This was to allow me some dignity for personal hygeine so I did not need a carer to bath me.</p> <p>I had an occ health when first diagnosed 12 years ago as I am struggling more they have been asked to come back in, it will be months before I see anyone and this is where small aids become difficult to use, i purchase electric tin opener as can not operate hand one . But what aids do people get from local authorities or nhs to take this into account it would need to be equal accross the whole country and time lined so it is helpfull</p> <p>9) If each individual was to be assessed then the assessor could ask the questions i.e. showering , cooking etc and keep the form to what functions are able to do and diagnosis of illness and medication. - This may be a way to also find the small amount of people who work the system.</p> <p>Most importantly it must not make people loose their dignity or make them feel to be scroungers of society. Currently the media coverage is managing to do this.</p> <p>10) As previously stated I have a number of health care people that I see, but none have the holistic picture - maybe it needs my medical records to be accessed by a professional, i do not know if social work , occ health feed into them as well but it may be an option. I had no problem being assessed and the doctor who attended gave my husband advise of crossroad care to give him respite that we would not have known about.</p> <p>11) If you are genuinely ill and getting fuinding from the state you should be prepared to have an assessment. However it has to remain dignified for the individual - it should not feel as if you are scrounging from the state.</p> <p>I think there may be difficulties if a person who does not know you carried out the assessment went on a good day / but if they have written evidence before hand from a source they should know -I would be concerned if it was a lay person carrying out the</p>

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	<p>assessment and they did not have a good medical background</p> <p>12) I currently get the highest level of both care and mobility, I have no magic cure for my illnesses, I have medical testimoney that this is as good as it gets - do I need reviewed, from my perspective no because I will only get worse I may have an extra tablet I am taking now but will that change my condition no. From the Government perspective they need to be seen to be spending the public purse wisely so yes I should be reviewed but ultimately that will just cost them the doctors fees etc - It will not change my entitlement. However who decides should I or should I not be reviewed ? It may be worth having a written review for people in my position that the GP can countersign that I have not improved since being on it. If the GP refuses to sign what I have written then it calls for a full review or the GP box could be filled without me seeing and they send direct to DLA</p> <p>13) Remove the fear that the benefit will be removed as soon as a change is notified or it will instigate a review. Currently it is a paragraph in your yearly award letter - it may be that you have to tick and sign this for no changes or a box for updates.</p> <p>14) Where they can get additional help not necessarily financial like - respite care for carers etc. Sign posting to various departments etc</p> <p>15) When first ill, it takes a long time to get your head around the fact you life will never be the same again especially if you are younger when it happens to you - enforcing someone to access a service will not work it will make genuine people bacl of - it could be when people are assessed similar to when the LA came out to my old neighbour to change her lease when her husband died gave her the forms and information on housing benefit and pension credit this service was helpful to her and allowed her to access other benefits - something similar by the assesor could work</p> <p>16) My family have helped me as I do not know where else to get money, the occ health gave me little aids that were helpful. the money I get goes on what it is meant to go on - travel, mobility buggy, cleaner, care ther is nothing left for me to have the option of paying for a one of cost - currently I am desperately needing a new chair and   just do not have the means of getting it.</p> <p>17) The carers and professionals know about the children as well as the social services however the people who know best are the parents and they should be assessed - but the professionals opinion have to be taken into consideration as well as because people are living with it daily as a carer they can either look at it as its no problem i just do it or it can be a small problem that they make into a mountain - it is getting a realistic picture of the disability</p>
ONLINE208	<p>5) Parents of deaf children must regularly take them to Audiology and ENT checkups (plus more regular vision testing as Pediatricians and Educational specialists like to ensure there are no problems with sight when hearing is compromised). These hospital and specialist visits mean additional travel costs for families of deaf children, including time off work as appointments are typically during working hours - DLA is an important contribution to the costs incurred directly due to the disability of these children.</p>
ONLINE209	<p>1) insufficient opportunities and support for young people with severe learning difficulties to live independently and lead active social lives</p> <p>2) people with a life long condition or syndrome e.g chromosome abnormality where it is clear the the condition of the claimant will not improve and that the disability is lifelong should not be subjected to reviews but should be awarded indefinite awards</p> <p>4) over simplifying a massive range of disabilities and difficulties faced by a huge range of disabled people. you will have very different disabilities being awarded similar rates of benefit</p> <p>5) known syndromes which cause severe learning/physical disabilities are sufficiently understood by the medical profession to allow automatic entitlements in those cases.</p> <p>6) personal care, preparing food, dressing, washing, travelling around, accessing social and friendship opportunities, safety, not being left in a vulnerable situation, not being lonely, access to games,social activities, safely taking medication</p> <p>8) i think this is reasonable so long as you do not remove the ability to purchase these adaptations by removing/reducing the person's award.</p> <p>9) rather than submit a claim to be considered by someone who has not mer the claimant, the decision maker should visit the claimant at home to speed up and simplify award</p>

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	<p>making process</p> <p>10) professionals involved with claimant as well as carers</p> <p>11) hopefully would give quicker fairer awards so long as all healthcare professionals have clear criteria to work to that are not open to interpretation.</p> <p>12) if the initial award is at the highest levels and the claimant has a lifelong disability e.g syndrome or chromosome abnormality anywhere it is clear that the needs of the claimant will not reduce but only increase as they get older then the claimants should not face frequent reviews. young claimants with these types of disability however should be reviewed frequently as their needs will increase as they get older and their award is likely to be greater in the future</p> <p>13) a simple short form standard letter sent out 6 monthly reminding claimant of their responsibilities should be sufficient</p> <p>14) definitely a good idea. lack of knowledge of what is out there to help you is a major problem in this country</p> <p>16) not sure but presumably DLA is used for these costs</p> <p>17) as now by comparing how different the claimants needs are from a healthy child of the same age.</p>
ONLINE210	<p>1) Financial problems, things like mobility devices, taxis and personal assistance are not cheap. How easy information is to access, many grants and funds are poorly advertised, welfare rights organisations are having their grants cut around the country so this problem is only going to get worse. Stigma is another problem, government and tabloid rhetoric about "benefit scroungers" is unhelpful and means that disabled people experience hostility, mistrust and exclusion from society. People with mental health difficulties are particularly vulnerable to this because newspapers often only mention mental health in reference to violent criminals.</p>
ONLINE211	<p>1) Lack of access to buildings and transport. Buses only carry on wheelchair (none if a pram/buggy is on board). Lavatories on trains are not disability friendly. The London Underground is virtually a no-go area. There can also be problems with communication if people with disabilities have difficulty expressing themselves verbally.</p> <p>2) It is vital that people who are in residential accommodation retain the mobility element of DLA. It is not fair to compare people in residential accommodation with those in hospital, as the former can live independent lives, shopping, visiting friends, going to their place of work, worship or college for example. Many people with disabilities simply cannot travel on public transport and this move would take us back to the dark days when they would be effectively locked away. It is unrealistic to expect the providers of residential accommodation to provide the transport as, again, this would not allow those they support to live as individuals as they would have to travel in groups at times that suited the majority, not the individual.</p> <p>4) No because it will risk becoming more subjective and dependent on who carries out the assessment. A borderline higher rate recipient might be judged to qualify for the lower rate and therefore will not be funded sufficiently to maintain independence. The problems will arise if need is not assessed accurately or often enough to reflect changes in need.</p> <p>5) There should be automatic entitlement for certain conditions. E.g. permanent disabled wheelchair users and those that are sight impaired. However 2 individuals who have the same condition may not require the same level of support. Individuals needs should always be assessed and reviewed.</p> <p>6) It is vital for people who are least able to lead full and active lives to be as independent as possible. They must be able to attend appointments at hospital, GP surgeries dentists etc but they must also be able to go shopping, visit family and friends, attend college, work and places of worship. In short, they should be able to do the things that people who can lead full lives do. Long distance journeys are particularly difficult because trains do not have disability friendly lavatories.</p> <p>7) Assessors need to be expert in a wide range of disabilities and review individuals on a regular basis. They should also be aware of the need to be person centred and put the people with disabilities and those who are knowledgeable about them and care for them, at the centre of the assessment process.</p> <p>8) Yes it should. Wheelchairs, communication aids, walking aids and hoists are prime</p>

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	<p>examples. Assessment should also take into account any aids that might be needed , For example, a new aid might become available. Different aids might become needed as a condition deteriorates, or it may simply be the case that the person with disabilities is unaware of an aid which would improve his or her life.</p> <p>9) The form could be made easier to complete in many ways; using tick boxes and having it completed verbally for people who have difficulty in reading and writing. Information should be easy to access and in different formats including online. Individuals should be written to and alerted. As should those who support them, including medical professionals</p> <p>10) Supporting evidence will vary enormously depending on the individual case but those best able to contribute are GPs, social workers,health care professionals carers, physiotherapists, family and friends and vitally, the individual themselves.</p> <p>13) It is important to be very clear in communication and highlight that notification of changes could lead to more appropriate support and that it is helpful to the individual to report any changes. It would also be necessary to point out that spot checks can be carried out and that ultimately benefits could be withdrawn.</p> <p>?) Aids and adaptations are funded in various ways:  Residential /nursing from care providers fund.  Community from social services/health fund  Communication aids from personal funding or charitable trusts  Enviromental controls can be provided by health but are often privately funded.  As long as the individual does not have to sacrifice support, the PIP should be flexible to meet needs.</p> <p>?) All health professionals need to be aware. It would be ideal if there was a 'one stop shop' e.g. an expert at each GP's surgery as well as a helpline, to avoid having to get information from various sources. The most inportant thing to avoid would be confusion and conflicting information and having to shop around for information.</p> <p>?) Children's independence must be developed from as early an age as possible, therefore equipmentand aids mustbe assessed.</p> <p>We have already stressed the importance of person centred planning. This is equally as important for children and adults.</p> <p>?) Individuals would need to be very clear about the eligibility criteria and differeing levels of payment. As with a previous question, availability of information in different formats, including online would be vitally important as would a well staffed helpline.</p> <p>?) None. Each person is an individual and their disability and resultant needs should be assessed as such.</p>
ONLINE212	<p>1) The main barrier to disabled people leading full and active lives is their disability itself. The social model of disability does not take account of the fact that many are 'disabled' by chronic health conditions. No matter how much adjustment is made to the physical environment, the pain, exhaustion or memory and concentration problems caused by their illness (or as side effects of the medications they take to control their illness), remain insurmountable barriers to full participation.</p> <p>Little has changed in real terms since the 1990's, despite legislation; for example, although busses are required by law to provide spaces for wheelchair users, there is no legislation to ensure that such spaces are available to said wheelchair users, often they are occupied by parents with baby carriages. Bus drivers have no authority to make passengers move and make space for a wheelchair user, thus the law is ineffective. Likewise, schools are required to make 'reasonable adjustment' for disabled parents of children at their school, however, my son's school (judged 'outstanding' by ofsted) has a reception area, and uniform shop inaccessible to wheelchair users, and they do not consider it 'reasonable' to change this.</p> <p>My local sports centre has only one accessible changing room, and this has on several occassions been unavailable to me, as it is used by non disabled patrons, and even staff. Most public buildings such as hospitals and libraries, as well as large supermarkets are now physically accesable, but the rest of the world is not. Even where the building itself is accessible, often designated 'disabled parking spaces' will be abused by non disabled people, and nothing is done to prevent this. My local supermarket manager told me that he could not risk the safety of his staff, by instructing them to enforce the rule that only those with 'blue badges' should park in such spaces. I have been told by a representative of my sons school that non disabled teachers parking in disabled spaces is preferable to them having to park off the school site and thus be late to class! My local hospital site team has</p>

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	<p>no power to fine or clamp those using such spaces.</p> <p>The preamble to this consultation states that it is now universally accepted that disabled people should be able to take full part in life as non disabled. Sadly, this is simply not the case. Many organisations and individuals pay lip service to this idea, but do nothing to fully impliment it.</p> <p>Employment oportunities are resricted, not only by the effects of one's disability and chronic health problem, but also by the attitude of employers that such individuals would be costly to employ. The Access to work fund has been used by many to facilitate return to employment, and yet this vital fund has been cut by the coalition Government, further restricting the opportunities for disabled people.</p> <p>The situation for wheelchair users currently is the 'worst of both worlds'; not only is much of the world inaccessible to us,(and always will be) but as it is supposed by many to be fully accessible, we are seen as whinging, and making a fuss about nothing when we point out our difficulties.</p> <p>People who are unable to walk and who rely on wheelchairs are unable to access many services and social activities due physical barriers, the world is not flat.</p> <p>2) Entitlement to 'care' (or daily living component) should continue to apply to those unable to cook a main meal.</p> <p>Entitlement to the higher Mobility component should continue for those who are 'unable or virtually unable to walk', regardless of how far they manage to mobalise a wheelchair.</p> <p>THE WORLD IS NOT FLAT, and being able to propel a wheelchair, does not negate the problem of being unable or virtually unable to walk. Wheelchair users are, for example, completely unable to mobalise when there is snow and ice on the ground, and will have considerably more difficulty negotiating a slope (or even a ramp), than someone who can walk.</p> <p>The disregaring of any walking acheived whilst in 'severe discomfort' should continue.</p> <p>The effectivness of mobility aids to facilitate walking should also continue to be considered.</p> <p>Someone who is otherwise fit and healthy who has, for example an artificial leg, but is able to walk quite normally, should continue to be ineligable, where someone with an artificial leg, who can only walk with considerable discomfort should continue to be entitled.</p> <p>Evidence from Consultants, occupational therapists and other health professionals involved in the care of the individual, and submitted by the claimant, should continue to be considered. These should carry more weight than a short assesment carried out by a DWP health professional, who does not know the claimant. However, it should be recognised, that the absence of such evidence, does not imply that the claimant does not have needs.</p> <p>Individuals with severe disabilities and health problems, from which they have no propect of recovery,(for example spinal injuries) should continue to have indefinate awards, without the need to constantly reprove their needs every few years.</p> <p>3) The criteria for DLA (or PIP) has to be subjective, as every individual is affected by their disability differently.</p> <p>The ability to 'mobalise' using a wheelchair, does not negate the difficulties caused by the inability to walk. Despite legislation, much of the world in inaccessible to wheelchair users. Even where access is available, disabled parking spaces are often abused and not available to those who needs them, this results in the facility being inaccessible, even though it is technically accessible.</p> <p>Issues such as snow or ice, which may cause some problems for able bodied people, have a huge impact on wheelchair users, and result in them becoming immobile.</p> <p>Many pavements are not 'wheelchair friendly', sudenly narrowing, or stopping altogether. not having dropped kerbs, or such dropped kerbs as are provided being blocked by inconsideratly parked cars. These things are not minor problems to wheelchair users, but inpact in a very real and negative way on their ability to lead their lives.</p> <p>Personally, as a wheelchair user, one of my greatest costs is transport; my powered chair, and my motorised vehicle. I am unable to walk to the shop, for example, and the route is inaccesible to wheelchairs, so i must therefore use my car for even the shortest of journeys. I chose to use my higher rate mobility component of DLA to hire a car through the Motability scheme, this costs almost £50 a week, additionally i must buy fuel for the car.</p> <p>My Local PCT, in common with many others, does not provide powered wheelchairs for anyone who is ambulant, at all. As i am able to walk a few yards inside by home, i do not qaillify. I have been provided with a manual wheelchair, but as i am unable to self propel</p>

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	<p>due to my condition, i have to rely on family members to push me. In order to have some independence, i have purchased a powered chair, these cost several thousand pounds new, and even the second hand one i now have, cost several hundred. Additionally, i have to pay for servicing and the cost of charging the batteries.</p> <p>Public transport, despite legislation, remains inaccessible, as there is no law preventing parent's with baby carriages from using the wheelchair spaces, and bus drivers have no authority to require that they give up the space. This frequently results in wheelchair users being unable to board the bus, and having to sit and wait for the next bus. Unlike able bodied people, wheelchair users are unable to move around to keep warm, and are more likely to suffer cold related problems such as frostbite and hypothermia. For this reason, many do not attempt to use buses, (despite having a free bus pass) and therefore have to rely on cars. This is not a hypothetical situation, this is the reality for me.</p> <p>Another high cost for me, is heating. As i am unable to work because of a chronic pain condition, i am at home all day. Since i cannot move around to keep warm, i must keep the heating on. My pain condition is worsened by becoming cold. Many other disabled people are in the same situation.</p> <p>The additional cost of food is also an issue. Firstly, for those unable to prepare a meal for themselves,(who do not have other family members to do so) the cost of 'ready meals' and takeaways, which is far greater than making meals from scratch. Secondly, for me, the additional cost of having to buy vegetables, rather than growing my own. Prior to my spinal injury, i was a keen gardener, and in the summer months could often feed the family almost entirely from things i had grown, i am now unable to do this.</p>
ONLINE213	<p>1) The main problem is how your disability affects you physically and emotionally. The second problem is financial which restricts where you can and can not go. Moving people away from DLA on to ESA or JSA is going to impact in a negative way as JSA was meant to be a subsistence level allowance which barely keeps body and soul together but does not allow you to participate in society. Anyone on long term sickness usually ends up broke and without enough money to participate in society due to lack of money, ie you have to think twice before you go out with some one for a meal or a cup of coffee. Or even buying birthday presents or christmas cards. Using public transport can also be an issue for some people I know mobility cars are available but not every one drives and some people live in rural areas and rely on bus services which are getting cut. Visiting hospital will also prove to be difficult in the future if a person loses their DLA or does not get put in the right ESA group as the government has tightened up on who is eligible for hospital transport. It can be very difficult to catch buses to a hospital and taxis can be too expensive if you have no family or friends to help it can be very difficult. It is also impossible to visit other people in hospital if finances are cut. By full lives I am assuming you are talking about people becoming financial independent through work. This is a pipe dream for many and I believe a Government ploy brought in to deny people money many have worked all their life and paid taxes thinking there would be support for them when they are ill. And now the government is moving the goal posts. Some people can manage with the support of families and friends and with the right financial help to work but that does not work for everyone. Some people just feel too ill and in pain to be able to work without their health suffering further. That is assuming that someone will employ them in the first place. One of the main barriers to work is acceptance by employers and work mates that a person has a specific problem and may be can not do or be expected to do as much as they themselves can do. If the Government really wants people to be employed they should allow firms to claim a tax rebate if they employ some one who is disabled. Also many work places are not yet adapted and suitable for everyone to work in and in the present climate it would be unreasonable to expect employers to pay thousands of pounds to make the work place conform to one suitable for a disabled person they might never employ. The government is tackling DLA at completely the wrong time it should focus its efforts on Tax evasion and come back to this at a later date when the economy is on a better footing. After all isn't the fraud rate only 0.5 percent. I do not think that the way the Government proposes to tackle changing DLA is the best way forward. By setting targets first presupposes people to believe that they are not concerned over a persons health but rather just saving money. Also at a time of high unemployment it is very hard for some one with a disability to find work and the additional worry of continuous health assessments particularly for long term conditions is not conducive to health.</p> <p>2) Everything should stay the same please do not meddle. If you think there is fraud going on then please investigate but do not change DLA for PIP</p>

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	<p>3) Read simplify for cut backs. Many disabled people face extra fuel/heating costs by staying at home all day and particularly in the winter months and not being as mobile they can find it hard to keep wark and they need more financial help with fuel bills. Also it can cost more money for transport as people sometimes need to use taxis more which are expensive. Many people have to pay for physical adaptions and better wheelchairs or bath aids or beds or clothes or special shoes etc that the nhs does not cover and so have to be paid for out of their income. The internet is a great boon for disabled people but not everyone has a pc or internet access and not everyone can afford it. Perhaps the government could arrange for help with the costs of a pc or free internet access for people with a disability. Some people also have to pay others to help them ie housework or personal care. Everyone's circumstances are different, and the best person to decide is the person who is disabled or their carer. The Government would be better leaving if it treated people like adults and let them make their own decisions.</p> <p>4) I fear that if there are only two rates instead of three that they may reduce the amount that people get instead of upgrading it. Or they may throw people off DLA in order to help the most vulnerable in society. However if they did that the people they deny care to will eventually reach a state where they become so ill they cannot care for themselves or other people who are looking after them cannot cope and so they will end up costing the Government more in the long run as the Government will have to foot the bill. No doubt in one of the new workhouses they will have to build or they will solve many peoples problems by bringing in voluntary euthanasia.</p> <p>5) Some health conditions or impairments should automatically be entitled to benefits - this would save a great deal of money constantly retesting people who would get entitlement anyway. Make DLA taxable to ensure that wealthy individuals do not benefit at the expense of the poor but at the same time make it available for those in work as well as those who do not work.</p> <p>6) Some people who are pracically bedridden and living on their own and are not in a home should get more money to help them lead more independant lives by being able to employ someone privately to do shoping or housework or washing or personal care. The amount of money the government currently pays is not enough. Activies essential for everyday life are being able to get up and dressed and feed or cook for yourself. Being able to go shopping or arrange for someone else to do it for you. Being able to either go out and meet friends at least once a week or have internet access. They should be able to live in accommodation that is warm and dry in a hooligan free zone and one where people could have home alarms installed to warn people if they need help. People should have enough money so they won't starve. And the Government should follow the Rowntree Trusts recommendation on how much a person should need to live to have a reasonable life.</p> <p>7) Sounds as if what you really mean is if you can be provided with an aid your income can be cut. Do not forget even with an aid sometimes for various reasons people are not able to use them and so without them they can be totally incapacitated. The qualtiy of an aid also can make a great deal of difference to a persons quality of life, not everyone can afford the best. Whilst the NHS can only afford the basic people should be allowed to use DLA money to upgrade or personally buy extra equipment. However due to the expense of a lot of disabled equipment I hope the Government is not considering that a person should have to pay for all their aids and adaptions out of the money they get from DLA as the money will just not stretch far enough. If a conditon is variable and fluctuates weekly than a person should be treated as if the condition is permanent. However if their condition can remain stable for months inbetween then perhaps a Doctor could be asked to provide evidence ie sicknotes when a persons condition deteriorates but they should be fast tracked on to DLA when that happens without having to go through all the paperwork again.</p> <p>8) Difficult to ansvere as many people have different aids and adaptions. Someone with a false limb can possibly manage quite well. But a wheelchair user could find more difficulty particualry travelling on public transport or gaining access to buildings. What would happen if some one in a wheelchair was working in an upstairs building and there was a fire and the lifts were out how would they manage. It is not clear if you are viewing this from the point of view of a person obtaining work or from a person usining aids and adaptions in their own home your question is ambiguous. People should be assessed as if they did not have aids and adaptions.</p> <p>9) The form should not be so repetitive. You must have enough information now on varioius illnesses that you could send a person a tailored form pertinent to their disability or</p>

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	<p>illness so that the questions would be more appropriate. The ones who have more unusual conditions would have to have a standard form. You should provide more information about the new benefit and your criteria for qualifying individuals in clear and straightforward English that cannot be misinterpreted.</p> <p>10) The first is the person claiming and the supporting evidence must come from their GP and Consultant or nurse or other medical advisor they are seeing not ATOS.</p> <p>11) The benefit is that the healthcare professional can ask the person directly what they feel they need to know about how their disability affects them. The difficulties is that time constraints and a persons demeanour may mean that they may not be effectively convey their problems to a stranger in a one off meeting. Perhaps these should only occur where there may be doubt over a persons application or if a persons needs are so extreme they need specialist help.</p> <p>12) If it is a lifelong condition then every 5 years should be appropriate. Depending on the severity of the condition it should then be 3 years then one year but nothing shorter. Some reviews could be simply by contact with the Doctor to check if the patient's condition has changed. Why waste money constantly reviewing people when all that is happening is that the patients condition is either stable or worsening.</p> <p>13) Do not penalize people if they are late in reporting changes may help in making people more willing to report a change in circumstances. Plus if you were to allow people to have support for say 3 to 6 months after their condition improved may help more people to come forward, as many people are basically honest.</p> <p>?) DLA has been very important but many people still do not know much about it or how or why people get it. The GP should do more to make people aware that they could claim it. When people are told they will be eligible for DLA they they should be provided with a full list of other services/entitlements they may be able to obtain. Information on many things like obtaining a Radar key or getting free diabetic batteries or hearing aid batteries are just not being made available to people.</p> <p>?) Do not believe introducing PIP can justify leaving people who have lesser disabilities without any financial support or other from DLA or the new PIP. If people need support they need support and money should be found from somewhere else instead of depriving people of support. Cameron lied he is not going to support the most vulnerable in society.</p> <p>?) Have a part of your website devoted to informing people about this and make it user friendly. Perhaps employ some people to have live chat sessions or skype sessions with to answer questions many people will have regarding applying for the PIP if you go ahead with it. For those without internet access they will visit their Doctors at some stage supply the GP's with leaflets which they will make available to their patients and ask the GP's to make someone in their surgery available to give people help with queries.</p> <p>?) I don't see anywhere in this about helping carers. If many people get removed from DLA then the people getting carers help will also stop but they will in many instances still have to support that individual. Therefore two peoples lives will be disadvantaged. Carers are being trodden underfoot again. Do you actually pay attention to consultations or do we only think we live in a democracy.</p> <p>By the way this is not the easiest web site to negotiate or leave responses too. Please leave DLA alone.</p> <p>?) I think it would mean more hardship for people and impact adversely on their lives. Although I wish you would not talk as if PIP was a given.</p> <p>?) Many people get so many aids and adaptations from the NHS but some have to be paid for privately. You do not make it clear how much money you intend to allocate someone as a PIP so how can you expect someone to judge whether they should spend their money on an aid or adaptation or will they need to keep it for help with personal care or just living costs.</p> <p>?) Not sure but perhaps a person could be assigned a card to access certain services to ensure they either get them free or discounted. However be warned against asking someone to give you permission to share their information across all government departments a person should be asked individually for each department. I think this is important as the Government does not have a good track record with regards keeping peoples personal data secure.</p> <p>?) There will always be a number of people who cannot access on line information and CAB or other carers organisations should be the ones who provide advice and support to these claimants. Please do not have a computerised tick box system which does not fully take into account an individual persons circumstances.</p> <p>?) Will the children grow out of their disability will it get worse. Who will be looking after</p>

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	<p>them how much extra time do they have to devote to a disabled time than one that is not disabled. Does one parent have to give up work to look after a disabled child and does this have financial implications on the parent. How best can you support a child with education and home care for them to live a normal life at home. What support will you give them when they become adults what provision will be laid down for their future.</p>
ONLINE214	<p>1) Access to building = No amount of money helps, but the legislation does  Transport = Free bus travel is a great help  PIP will help with additional expenditure on continence control and additional grooming and clothing costs.  2) The recognition that different people have different needs.  It is difficult to balance simpleness with accuracy.  For example paying everyone the same for mobility is easy and simply but may not address different peoples needs fairly.  The idea of letting people choose how they @carve up@ the different components is a good one.  3) The additional costs of batteries, maintainence, insurance, electricity for a mobility scooter.  Adaptations to the home, rails etc., additional equipment, frames and sticks.  If you cant work - Living!  4) See above Simplicity Vs Accuracy</p>
ONLINE215	<p>1) LACK OF TRANSPORT AND FINANCES  2) I BELIEVE THAT IT HAS BEEN MADE MORE DIFFICULT TO GET D.L.A. THE GOALPOSTS HAVE BEEN WIDENED,MY CIRCUMSTANCES HAVE NOT CHANGED IN THE LAST 7 YEARS  3) TAXI, BUS, TRAIN FARES TO BE ABLE TO GET AROUND THIS IS NOT ALWAYS AN OPTION,  4) THERE HAS ALWAYS BEEN TWO RATES THE HIGHER AND THE LOWER SO HOW WILL IT MAKE IT EASIER, APPROPRIATE LEVELS OF SUPPORT NO LONGER EXIST,  5) ALL BENEFITS SHOULD BE PAID ON MERIT AND PAID TO THOSE WHO CAN PROVE THAT THEY ARE IN NEED OF THE D.L.A, CERTAIN IMPAIRMENTS OR HEALTH CONDITIONS SHOULD BE GRANTED THIS BENEFIT AUTOMATICALLY, MORE INVESTIGATIONS SHOULD BE MADE FOR OTHER CLAIMS, I:E: DOCTORS, HOSPITAL AND CLINIC REPORTS, THESE WOULD BE FROM PEOPLE WHO KNOW OR HAVE HAD DEALINGS WITH THE CLAIMANT AND UNDERSTAND HIS/HER CONDITION AND WOULD BE ABLE TO PROVIDE A MORE PRECISE AND ACCURATE ACCOUNT OF THE CLAIMANTS CONDITION  6) WITH THE APPROPRIATE BENEFITS PEOPLE WILL DECIDE THEMSELVES WHICH ACTIVITIES THEY ARE CAPABLE OF AND WILL DO WHAT THEY CAN AND WHEN THEY WANT EITHER AT HOME OR AT A FITNESS CENTRE IF THEY CAN ACTUALLY GET OUT  7) MEDICALS NEED TO BE MORE STRINGENT, NOT BY A FLYING DOCTOR AS IN MY CASE HE SPENT ABOUT 10 MINUTES TALKING TO ME AND 5 JUST LOOKING AT MY LEG AND WATCHING ME TAKE ABOUT 5 VERY SHORT STEPS THEN DECIDING THAT I WAS NOT ENTITLED TO D.L.A.,AND CONSEQUENTLY WAS DENIED MY BENEFIT  8) ALL AIDS THAT ARE USED BY DISABLED PEOPLE SHOULD BE TAKEN INTO CONSIDERATION.  9) LESS STUPID QUESTIONS, GIVE GUIDELINES ON THE FORMS  10) IS THERE ANY POINT IN GIVING SUPPORTING EVIDENCE FOR A CLAIM ?, I MYSELF APPEALED AGAINST THE DECISION TO CANCEL MY D.L.A. AND I PRODUCED FURTHER EVIDENCE OF MY CONDITION WITH A LETTER FROM MY DOCTOR, I HAVE BEEN TOLD THAT BECAUSE I DID NOT PRODUCE THIS EVIDENCE AT THE APPEAL HEARING IT WILL NOT BE TAKEN INTO CONSIDERATION, THIS IS AGAINST ALL NATURAL JUSTICE, EVIDENCE IS EVIDENCE NO MATTER WHEN IT IS PRESENTED AND SHOULD BE TAKEN INTO CONSIDERATION, THIS LETTER FROM MY DOCTOR EXPLAINS IN DETAIL MY CONDITION AND IS A FAR BETTER AND PRECISE ACCOUNT OF MY CONDITION THAN I COULD WRITE YET IT HAS NOT BEEN TAKEN INTO CONSIDERATION, IT GOES TO PROVE THAT THE BEST PERSON TO APPROACH IS THE CLAIMANTS Dr, CONSULTANT,OR ANY MEDICAL BODY THAT HAS HAD DEALINGS WITH THEM, A MEDICAL OFFICER WHO HAS NEVER SEEN</p>

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	<p>YOU BEFORE OR KNOWS ANYTHING ABOUT YOU SHOULD NOT BE THE SOLE PERSON THAT YOU TAKE NOTICE OF TO CANCEL A D.L.A. CLAIM, I ACTUALLY WROTE ON MY CLAIM PACK ASKING THEM TO CONTACT MY DOCTOR FOR A MORE PRECISE AND ACCURATE ACCOUNT OF MY CONDITION BUT THEY FAILED TO DO THIS, I BELIEVE HAD THEY DONE SO I WOULD NOT BE IN THIS POSITION NOW.</p> <p>11) IN MY EXPERIENCE EVERY-TIME I HAVE HAD A MEDICAL FOR D.L.A. IT HAS BEEN A FACE TO FACE DISCUSSION, AS IT SHOULD ALWAYS BE, THERE IS NO REASON NOT TO HAVE THIS PROCESS, SO IT IS NOT NEW</p> <p>12) IF A CLAIMANT IS DUE FOR A REVIEW FOR D.L.A. THEN HIS /HER G.P SHOULD BE THE FIRST PERSON TO BE INVOLVED, MAYBE JUST A SHORT LETTER OR A SPACE ON THE FORM THAT THE CLAIMANT HAS FILLED IN SO HIS/HER DOCTOR CAN READ AND SIGN TO AGREE OR DISAGREE WITH THE CLAIMANTS STATEMENT,IF YOU THEN THINK IT IS NECESSARY TO GET A SECOND OPINION THEN DO SO THERE WOULD BE LESS NEED FOR FLYING DOCTORS THIS COULD SAVE MILLIONS PER YEAR</p> <p>?) ALL ADVICE AND INFORMATION IS WRITTEN BY PROFESSIONAL PEOPLE, THIS IS NO GOOD TO THE LAY PERSON, QUESTIONS ARE OFTEN REPEATED IN DIFFERENT WAYS AND THIS GETS CONFUSING, WHY NOT GET LAYMEN UNDER SUPERVISION OF A PROFESSIONAL TO PRODUCE FORMS THAT WILL BE UNDERSTOOD BY ALL SOME WORDS ARE NOT UNDERSTOOD BY MOST PEOPLE.</p> <p>?) THOSE WHO DO NOT CLAIM ARE POSSIBLY THE FORTUNATE FEW THAT DO NOT NEED TO BE HELPED, THERE HAS NEVER BEEN ENOUGH ADVICE OR SUPPORT IN ANY CLAIM AREA WHERE YOU ARE TOLD 'WELL YOU SHOULD HAVE CLAIMED FOR THIS OR THAT'IF YOU DON'T ASK YOU DON'T KNOW, ITS NEVER BEEN OFFERED.</p> <p>?) NO, PEOPLES NEEDS CHANGE FROM MONTH TO MONTH, YEAR TO YEAR, AND SO ON, A ONE OFF PAYMENT WOULD NOT BE SATISFACTORY AND ANY FURTHER AIDS AND ADAPTATIONS SHOULD BE PAID FOR AND SUPPLIED AS AND WHEN NEEDED, THAT QUESTION SEEMS TO BE A BIT OF A COP OUT, IF SOMEONE DECIDED TO TAKE ONE OFF PAYMENT THERE WOULD BE NO HELP IF THINGS GOT WORSE FOR THAT CLAIMANT THERE WOULD BE NO FURTHER HELP.</p> <p>?) THERE SHOULD BE NO DIFFERENCES KEEP THE RULES AS THEY ARE OR EVEN BETTER MAKE IT EASIER FOR PARENTS WITH DISABLED CHILDREN TO CLAIM.</p> <p>?) D.L.A. WAS AND IS VERY IMPORTANT TO ME, AS I HAD A MOBILITY CAR INSTEAD OF THE PAYMENT I WAS ABLE TO GO BACK TO WORK 2 YEARS BEFORE MY INCAPACITY BENEFIT CAME TO AN END, I DID NOT WANT TO JUST BE A NUMBER I WANTED TO WORK AND WAS ABLE TO FIND A JOB THAT I COULD DO, ONLY BECAUSE I HAD THE CAR, I FIND IT VERY DIFFICULT TO WALK WITHOUT CRUTCHES AND DID NOT NEED THEM ON A REGULAR BASIS AT MY PLACE OF WORK, NOW I WOULD NEED TO WALK 600 YARDS TO MY NEAREST BUS STOP BEFORE I GET ANYWHERE NEAR IT I AM IN A LOT OF PAIN AND DISCOMFORT, THEN HAVE TO STAND AND WAIT FOR A BUS, THEY NEVER RUN TO A TIME TABLE SO IT COULD BE A LONG WAIT, IF I'ME LUCKY IT MIGHT ONLY BE A FEW MINUTES, THEN TO TRAVEL ANY DISTANCE OVER ROAD HUMPS, POTHOLES AND OTHER FAULTS IN THE ROADS THAT MAKE BUSES BOUNCE IS ALSO VERY PAINFUL UNLESS I CAN TRAVEL WITH MY FOOT/LEG OFF THE FLOOR, THEN IF I WERE TO GET TO A PLACE OF WORK I MAY HAVE TO HOBBLE ANOTHER CONSIDERABLE DISTANCE AND IF AND WHEN I FINALLY GET TO MY DESTINATION I AM NO GOOD FOR NOTHING AS THE PAIN WOULD BE INTOLERABLE, OH I WAS ADVISED AT MY APPEAL HEARING THAT I SHOULD TAKE STRONG PAIN KILLERS TO HELP ME THROUGH THE DAY, THIS ADVICE WAS FROM THE DOCTOR SITTING ON THE APPEAL PANEL, AS THE ONLY EMPLOYMENT I CAN REALLY DO NOW IS LIGHT DRIVING WORK I DON'T THINK THAT WAS VERY GOOD ADVICE AS WE ALL KNOW WHAT STRONG PAIN KILLERS DO TO PEOPLE. I AM ENTITLED TO GO TO WORK, I AM ENTITLED TO ACCESS OTHER SERVICES, BUT BECAUSE OF CHANGES IN THE SYSTEM I AM NO LONGER ABLE TO, SO YES THE D.L.A. WAS VERY IMPORTANT TO ME.</p> <p>?) THAT QUESTION IS CONFUSING, IF YOU MEAN THE IMPLICATIONS THAT DISABLED PEOPLE MAY EXPERIENCE WITHOUT D.L.A. OR P.I.P PAYMENTS, IN MY CASE I AM ALMOST HOUSEBOUND NOW DUE TO LOSING MY CAR, I ONLY GO OUT</p>

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	<p>WHEN ABSOLUTELY NECESSARY, AND I AM SURE THERE ARE MANY MORE LIKE ME.</p> <p>?) I HAVE IN THE LAST 9 MONTHS HAD 4 MEDICALS, ALL BUT THE D.W.P. MEDICAL OFFICER WHO VISITED ME IN MARCH HAVE AGREED THAT I AM DISABLED, A SURREY COUNTY COUNCIL MEDICAL OFFICER EXAMINED ME FOR ABOUT 50 MINUTES, AND OBSERVED HOW I WALKED FOR ABOUT 50 YARDS, THIS WAS TO RENEW MY BLUE BADGE, (DISABLED PARKING PERMIT), THIS WAS QUITE RIGHTLY GRANTED ON THE FINDINGS OF THEIR M.O., MY DOCTOR ALSO GAVE ME A CHECK UP AND REFERRED ME TO THE HOSPITAL FOR X-RAYS, THEY HAVE ALSO CONFIRMED THAT I HAVE PERMANENT NON-UNION FRACTURES, SO IT PROVES THAT MY CONDITION HAS NOT IMPROVED OVER THE LAST 7 YEARS, SO WAS THE D.W.P. DOCTOR RIGHT IN HIS FINDINGS AFTER JUST 15 MINUTES, I DOUBT THAT VERY MUCH, THEREFORE ALL EVIDENCE MUST BE OBTAINED BY THE D.W.P. AND TAKEN INTO CONSIDERATION, SHARING INFORMATION IS VITAL TO CLAIMANTS</p> <p>?) WHOEVER READS THE APPLICATIONS FOR D.L.A. OR P.I.P, SHOULD TAKE ALL THE INFORMATION INTO ACCOUNT, EVEN IF THAT EVIDENCE WAS SUBMITTED AFTER THE THE APPEAL HEARING, I HAVE BEEN TOLD THAT BECAUSE THAT EVIDENCE WAS NOT PRODUCED AT THE APPEAL HEARING IT CANNOT BE TAKEN INTO ACCOUNT, I HAVE LETTERS STATING THAT THEY CAN CHOOSE WHAT EVIDENCE THEY WANT TO USE AND NOT TAKE ALL THE INFORMATION INTO ACCOUNT, YET I ALSO HAVE A LETTER STATING THAT A CLAIMANT CAN PRODUCE FURTHER EVIDENCE TO HELP HIS / HER CLAIM AT ANY TIME, THIS IN ITSELF IS CONTRADICTORY,</p>
ONLINE216	<p>5) I am concerned about my grandson aged 13 with cerebral palsy and severe learning difficulties, he cannot walk or speak and needs 24hr care, and will as time goes on need increasing residential care, he is getting heavy and it is very tiring for the whole family. Outings are very important and help to stimulate him, making his behaviour easier too. I feel that it is essential that the mobility component of DLA be safeguarded for conditions such as his. Let us have a society that does look after its most vulnerable members, I believe many fit older people would gladly relinquish some of their many benefits if we knew it was going to ensure as happy a future as possible to those of the younger generation who have a severe health problem</p>
ONLINE217	<p>1) With my illness which means i am in constant pain and have a huge problem with fatigue and could not commit to a fulltime or even a part time job. I cannot see how an employer would want to take someone on with these problems? I had my own business and certainly couldnt take anyone on with someone who needed to have time off on a regular basis? The stress of having to try to get to work would exacerbate my symptoms and i could see fellow colleagues who were fit and able finding it all very unfair. I know people arent allowed to discriminate but we have got to be realistic here.</p> <p>3) I need help with housework for example a cleaner. I need someone to help with the gardening. I am unable to do any of these things without being in severe pain. I also need a car as using public transport would be too difficult with my mobility needs as alot of trains and buses will not accept mobility scooters with prior notice which is not realistic really. I need help with extra fuel as i tend to have to drive more now i am disabled due to being unable to walk very far.</p> <p>4) I think the current way we have two components is easy to understand, i think doubling this could make it more difficult to understand. Why change this?</p> <p>5) I think some health conditions that are long term and not going to change should receive an automatic entitlement, the rest should be on the needs and circumstances of individuals.</p> <p>6) Being able to wash and dress yourself, help around the house, help with getting out and about.</p> <p>7) You will need lots of information about these conditions as it seems to me alot of doctors assessing for DLA do not have enough knowledge of these illnesses</p> <p>8) You should not take into account any aids, it should be on the persons ability as the person they are and how their condition affects them!!!</p> <p>9) Reduce the amount of questions. Include a leaflet with the form explaining about the new benefit.</p> <p>10) I would say your doctor and any specialists you have seen will provide a clear assessment of ability.</p>

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	<p>11) I have heard of many negative meetings of people with healthcare professionals who seem to totally disregard what the person is saying and seem to write down just what they want to!!!They are dealing with vulnerable human beings here!!They should be trained to deal with disabled people in a respectful way and to write down the correct information.They should have a good knowledge of the various conditions they come across.</p> <p>However i do agree that face to face discussions are neccessary but with the knowledge that these meetings can be extremely stressful for the ill or disabled person or should be allowed for.</p> <p>13) Sending out reminders with any letters etc?</p> <p>14) I find my motability car invaluable in giving me my independence and am able to get my children around.It takes away alot of the worry.Any help with getting support for your condition is also very important.</p>
ONLINE218	<p>1) 1/ Public/ privately sourced Transport. The worse the disability, the less one can use the limited facilities currently provided for the disabled.E.g I have limited arm movement and have difficulty pulling tickets from machines, reaching to push buttons, etc.</p> <p>2/ Access to public buildings,shops etc, often difficult and hindered by able bodied people/passengers.</p> <p>3/ If away from home finding suitable rooms in hotels, etc.</p> <p>4/ From my professional experience, I know that many Architects of both new build and refurbished properties have little knowledge of space or door approach angles required for wheelchairs.</p> <p>2) It is essential that the ability to retain DLA+mobility component (or a similar benefit) continues after reaching retirement age for those who need it for this reason: On reaching retirement age disabilities such as mine (a congenital neuropathy in all 4 limbs) become more aggressive and the need for more help in the form of aids and personal care rises. The cost of my personal care at age 75 is nearly twice that of the benefit received.</p> <p>However, thanks to the DLA benefit received over years I was able to maintain my own transport arrangements and so was fortunate to have held down well paid jobs. The amount of income tax I paid was substantially more than the benefit received</p> <p>3) I agree that there is a strong case for looking at extra costs at regular intervals but on an individual basis. However this must not only recognise individual costs but should take account of the disabled's own will and determination to get the best possible employment if employment is a realistic option at all.</p> <p>4) First: depends entirely at what base level the benefit is set. Second: criteria must be crystal clear and based on easily understood factors to avoid disputes</p> <p>5) In practice there will be cases that need regular review and others that are obviously long term or incurable. These latter cases should only be reviewed when requested by the person concerned, as from my own experience I know that some conditions will only get worse.</p> <p>6) To live independently one has to have the ability to be able : 1/ to communicate effectively with others 2/to move around independently using aids such as walking frames, manual chairs or electric wheelchairs/scooters, drive a car. 3/ to dress and manage your bodily functions independently of help. 4/to feed and cook for yourself. 5/ to manage your financial and daily affairs.</p> <p>However, most conditions get worse as age progresses and inevitably further help will be required as time moves on.</p> <p>It is important that where the individual concerned has a partner it is not assumed in the assessment that that partner will do some of the caring! They may well do so but if they play an important part in the well being of the applicant this must be recognised in a positive way, not lead to a diminished benefit.</p> <p>7) regular review by way of assessment by specialists in the condition being assessed. However, some will give way to despair, others will fight and achieve more. The latter should not be penalised by being allocated to "one size fits all" category.</p> <p>8) 1/ The assessment needs to take into account the basic aids necessary to both live to a reasonable standard and carry out their employment, if they hold down a regular job. For example, I needed my own vehicle to carry out my job that required me to be able to visit</p>

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	<p>various locations. Later in life as my condition deteriorated I also needed an electric wheelchair to travel locally where necessary. This was funded by a government scheme to keep disabled workers employed and transported when necessary in my vehicle. I was fortunate to be able to self fund the necessary modifications to the vehicle, but this can be very expensive.</p> <p>The nature of my disability, congenital neuropathy effecting all 4 limbs, did allow me some limited walking ability in my younger days but carrying a normal briefcase was impossible because of my lack of grip and strength of my arms.</p> <p>This latter difficulty also meant that travelling on buses and the underground was impossible, unless accompanied by an able bodied colleague. Travel by overland trains was possible but the end stations needed to be close to home/or destination or else it was a black cab where one could get help to get in from the driver.</p> <p>2/ Assessing an individual needs by way of appliances must take account of the nature of the disabled person's equipment needs. If he/she has anything more than simple basic equipment, e.g walking aids, crutches and the like, the benefit needs to allow for costs associated with the particular maintenance and repairs the equipment needs. The more sophisticated motorised equipment needs servicing regularly, repairs occasionally and eventual replacement in the longer term.</p> <p>9) 1/ Keep it simple, as few questions and pages as possible. As many relevant questions as possible should be of the yes/no type and narrative answers avoided. Where narrative answers cannot be avoided, it must be clear to the applicant that these may be investigated. (By a home visit)?</p> <p>2/ A clear and unambiguous statement in a prominent position on the front of the form should make clear that this is an application for a government funded benefit to help those who are seriously ill or seriously disabled to fund the extra costs of living incurred by their condition and is not met by other government or local government funding.</p> <p>I would also suggest that these forms, when completed should be supported by a doctor's statement and countersigned by a responsible individual along the lines of that required for a Passport.</p> <p>10) To some extent I have answered this in Q9.</p> <p>A doctor's supporting statement (not just a signature) and validation by a recognised responsible individual as for Passports etc.</p> <p>11) For new claimants:</p> <p>1a/ A witness to show the disability is real and factually recorded.</p> <p>1b/ Finding the right qualified technical staff to do the assessment in sufficient numbers. I envisage both a Doctor and an Occupational Therapist.</p> <p>For the most part this will need to be done in the claimants environment.</p> <p>2/ Most new claims will need a home visit unless the claimant is known to be bed bound.</p> <p>12) 1/ I think this evidence and/or criteria should be medically based by either the relevant GP/hospital consultant/ Occupational Therapist where there is the possibility of recovering to normal health.</p> <p>Where the condition is not going to improve significantly over the persons life span and the needs for equipment may change or new appliances/equipment be required, re-assessment periods need to be flexible to suit the type of equipment used.</p> <p>2/ Yes, see above.</p> <p>13) This is covered in the annual letter claimants currently receive. It is difficult to see how it can be further reinforced except by redrafting the letter to include a more emphasis on the penalties for not doing so.</p> <p>An option to require a printed declaration to be signed and returned at regular intervals is an option to be considered but may not be cost effective. Bare in mind also that if someone is rushed into hospital, informing government departments may not be practical until recovery is well advanced.</p> <p>14) It really depends of the person concerned's own volition and their actual needs. Its all there on the internet today in some form but still far too fragmented and commercialised. Just understanding how this could be fed to applicants is difficult to imagine with so many options in equipment available.</p> <p>At the moment the best source of information comes from Occupational Therapists, especially those in private practice who tend to know suppliers in their area.</p> <p>Perhaps a government sponsored website of advice and listing approved specialist websites covering a range of similar and suitable products would be helpful.</p> <p>The availability of advice from government sponsored driving assessment centres on more</p>

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	<p>than driving is not always understood, for example on powered wheelchairs and scooters. Maybe the scope of such establishments could be widened or more similar establishments devoted to disabled living established by encouraging firms selling similar products to combine together under a government sponsored logo but this would be difficult to bring about. While there are a number of annual exhibitions every year showing various products, it is difficult to take an overall view and not be overwhelmed.</p> <p>One further and very important matter needs addressing from central government to local government, and that is the availability of staff and funding by Local Government for essential alterations.</p> <p>These often take years to happen and unless the person has private means can be literally confined to one room for years. Prisoners in jail get better!</p> <p>In my case when I had waited over 12 months just for a survey, I took steps to get advice from a private source and after a while managed to recover my costs from the Council concerned.</p> <p>15) Yes it would. The names of locally available Occupational Therapists could be given, but as I found when badly let down by my local Authority, independent advice is difficult to obtain and involves cost. Both hospital and NHS funded local OT's have a limited remit and can only advise on a limited range of equipment approved by their Authority. Private OT's are available but charge for their services.</p> <p>16) Not entirely sure that I understand the question properly? If you are suggesting that the PIP would be advanced as a lump sum to specifically procure an expensive piece of equipment without the need to enter into a monthly payment schedule, I think this would be welcomed as it will save interest costs and make bargaining easier.</p> <p>However, there are other considerations. These are:</p> <p>a/ safeguards must be in place to prevent the not inconsiderable sums being used for purchases other than the equipment intended.</p> <p>b/ Unless more than 12 months of the DLA could be advanced it is unlikely that some of the very specialised equipment could be funded.</p> <p>However, if this is not the case, and the benefit continues to be paid in installments, then surely this already happens with the mobility component of DLA? Many use their benefit to fund the purchase of wheelchairs and pay for Motability supplied vehicles? Assuming that this Personal Independence Payment includes allowance for mobility, what is changed?</p> <p>17) It is surely inevitable that a disabled child that has got no life shortening medical condition will be in need of variable financial support throughout its life and costs will be at a peak from early teens until young adulthood. Cost in the form of equipment such as wheelchairs will rise as his/her age rises.</p> <p>Cost could start earlier and last until fully adult if artificial limbs and the like are required. Regular yearly assessments will be needed until fully adult.</p> <p>?) While it would seem at first sight that there is plenty of room for the swapping of information between different government bodies, it has to be carefully managed to avoid leak of confidential information leading to identity theft.</p> <p>However I do have one or two potential savings, particularly at the local Authority end of the mobility chain where information about me is held but departments do not exchange that info. between themselves.</p> <p>1/ For example, in 2008 I obtained a specially modified van that was too large to get into my drive and I had to apply for a disabled person's parking space on the road. Although my disability needs have been in the LA's social services dept. since we first moved into the area 42 years ago and were updated in 2007 when I started to receive home care and I had been visited by their Care manager on that occasion, who had noted my disability and needs in some detail, in spite of this info. being available in the LA SS dept. I had to:</p> <p>a/ have a home visit by a council officer from the streets and roads section, who said that it was council policy that all applicants, in spite of her being satisfied that I was eligible, must be seen by the council's Doctor. Having arranged this visit to the Council's officers, the Doctor took one look and said "why have you been dragged in?".</p> <p>2/ One of the benefits attached to receiving the DLA is receiving a blue parking badge. Yet even though I have the DLA for life, my council still insists this needs renewing every 3 years. This involves getting an up to date photo and completing an application form. I also need to provide proof that I am in receipt of DLA, exactly as previously! (Incidentally it is not that easy in these days of photo booths if you cannot get out of your wheelchair! There is no other facility in our town. Another potential cost caused by the need to get a photographer to take this!)</p>

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	<p>So where the DLA is for life why can't the LA check the database at the Government Dept which holds it? And why cannot the badge be issued every 5 years or may be even longer? When over 70, the DVLA retains the same photo image for the rest of the person's life. Why cannot the L.A.do the same?</p> <p>This will reduce the cost to both the Council and myself.</p> <p>To summarise, once a Council is aware that they have a resident who might need help from them in one form or another, why don't they ask that person to sign a disclosure form for use internally by the whole of the Council, say every 10 years? Over the years I have completed various forms relating to my disability but when an essential need arises we always go back to square one!</p> <p>?) This answer assumes that your question means these passport benefits are with drawn completely! If still available but left to the individual to pursue is another matter but rather unkind!</p> <p>Could mean additional expence and agravation, in a nutshell!! This on top of an already frustrated lifestyle where budgets are likely to be already tight.</p> <p>Bear in mind that the disabled already, probably, have additional care and living expenses not met by normal people. Many simple DIY jobs around the house mean calling in the professionals.</p> <p>From my point of view all the savings that I identified add up to quite a sum, but hidden costs not normaly required by the able bodied amount to quite a sum also:</p> <p>Because I worked in a profession capacity, standards of dress had to be maintained. The primary effect of my disability is short and weak arms and legs. Bespoke talored suits and shirts were essential. Casual clothing bought off the peg needed alteration.</p> <p>?) 1/The jury is out here! One learns as one gets involved when starting to enquire about disability aids including vehicles.</p> <p>The passported other benefits that I have made use of are mainly mobility related,e.g:</p> <ul style="list-style-type: none"> <li>-Automatic right to blue badge</li> <li>-Vat free purchase of equipment like wheelchairs, walking frames and such.</li> <li>-Free road fund licence, if one has the mobility component of DLA</li> <li>-Free Dartford and other toll crossings</li> <li>-Free of congestion charging in London- other areas??</li> <li>-Relatively recent- VAT relief on modified vehicles purchase. Before that most vehicle manufacturers offered discounts to the disabled.</li> </ul> <p>For personal reasons, I have not used Motability vehicles myself because of their limitation on mileage-I averaged 15K miles p.a., while working and the nature of my journys and parking in central London meant keeping the body work in pristine condition was very difficult.</p> <p>Recently, because I now need a van with wheelchair entry and specialist controls I purchased it myself because of the long waiting list for such vehicles.</p> <p>2/These arrangements are pretty well explained when one digs into the detailed information, or while making enquiries of people specialising in disability, about buying a particular product, but I am not aware currently, of a Government comprehensive document/website.</p> <p>Another example of information that is little known is need to register an electrical vehicle (scooter) with the DVLA if it is capable of exceeding 6 MPH.</p> <p>?) It is hard to see how either the present arrangements or the proposed changes could be effected by either race or religion.</p> <p>But I can imagine that a (hypothetical manager) having to make the special arrangements for someone disabled,as required by disability legislation and therefore receiving benefits could be used by an unscrupulous manager to use either race or religion as an excuse not to employ or try to dismiss that disabled person</p>
ONLINE219	2) DLA SHOULD CONTINUE TO BE PROCESSED END TO END FROM INDIVIDUAL DBC'S
ONLINE220	<p>1) Personally my mobility is very limited. I find it hard to walk to bars and restaurants etc and I'm unable to participate in sports and leisure activities that I used to enjoy. As for other disabilities, someone who has a hearing imparement has great difficulty to communicating with the hearing community unless they are able to lip read, or peopel are able to sign BSL, that's if the disabled person can use BSL in the first place. Someone who is visually impared cannot interact with society as easily as someone who can see. Generally society disables the person, not the condition of the person, although this can</p>

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	<p>restrict what the person is able to do in normal life.</p> <p>Being able to make adjustments to your lifestyle can enable a disabled person to participate in whatever activity it is they wish to do, be it getting a car via motability, this allows someone who has great difficulty to get a car, which is a very expensive item, so that they can get around with relative freedom. Or they can get adaptations for their home, so that they can carry out day to day tasks. Some of these can be extremely expensive, and the benefit can make the difference between someone being able to afford these adaptations and not.</p> <p>2) I believe that splitting the mobility and help around the home sections of DLA are quite useful. It allows the benefit to be tailored to the individuals needs. I myself rely more on getting around than the help at home, although this is becoming more and more necessary as my condition deteriorates.</p> <p>Although the existing benefit is a little broad, it can cover a lot of different requirements with the same thing.</p> <p>3) I think transport (car etc) is one of the most expensive costs a disabled person can incur, as a lot of people are unable to use public transport due to mobility issues etc. I use the motability charity to enable me to have a car. This allows me to get to work and get out to shop etc, although shopping is very difficult for me now. In addition if someone needs to buy a mobility scooter etc, this has to be paid for somehow and the benefit can help in this. Other expenses can be adaptations around the home. I have had to convert my bathroom as I'm unable to use a bath now, but I had to pay for this myself, as I do not receive any other benefits and had to engage private contractors. other people may need other adaptations like stair lifts, kitchen adaptations, changes to the exterior of the house to enable access, aids to assist egting into and out of bed like hoists etc. All these are extremely expensive and sometimes have to be paid for directly from the person's pocket. Basically, anything that can enable to person to carry out daily life to near as normal as possible.</p> <p>4) Having two rates will allow people receive a reasonable level of assistance, although it could over simplify things to a certain degree. I know curently the mobility rate has 2 levels and the care rate has 3 levels. I would have thought that having similar rates would allow the govournment to administer the benefits more accurately, rather than covering everyone with the same umbrella. After all, they are trying to save money?</p> <p>However, if the 2 rates are administered by having small sub-levels in between, which are tailored to the individual's needs, then this could be a better way to save money, yet simplify the arduous and complicated process of filling in the claim forms.</p> <p>Of course, having 2 rates oer component will allow better administration and a more simplified claims process. You just have to be careful that the cut-off is well defined so as to avoid over paying someone who would normally qualify for the lower rate.</p> <p>5) Personally I belive that there should be a few conditions that entitle the person to the basic rates if P.I.P. However, there should be varying rates within those fields. For instance, if someone suffers from Muscular Distrophy, obviously in the early stages this can have a small effect on the person, but as it develops can be an extremely debilitating and sometimes fatal condition. The varying rates would allow a more accurate distribution of benefit to a sufferer, as it will progress and is incurable.</p> <p>I personally suffer from a very aggressive form of Rheumatoid arthritis. In some people, this can mean a bit of pain now and again, for others like myself, it can mean several joint replacements, numerous operations and several more to come in the future, all having a dramatic effect on the person's life. But just because I have suffered from a lot of joint damage doesn't mean that everyone with RA should is the same and should get the same rate as someone who has a very serious case of RA. The same goes to MS and suffers of other diseases. But where having a condition means that the person is going to need care and help from the very start, then this should be an instance where P.I.P is given automatically.</p> <p>Similarly, a person who suffers from sever mental disabilities, where they are unable to look after themselves and need constant supervision etc, then this should be an instance where a benefit should be given automatically, the same applies for someone who is born totally blind. Under normal circumstances, this is going to remain so, and this person is going to need help for the rest of their lives. I belive that again, this in an instance where benefit should be automatic.</p> <p>I appreciate that criteria varies for every condition, and it's a very complicated process to try and cover every form of disability, but there are instances where there are grounds for</p>

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	<p>automatic P.I.P.</p> <p>6) The ability to get around independantly, without the need to rely on others to get you somewhere you want to go, unless of course that having an assistant is necessary. The ability to wash, dress one's self, or with the assistance of someone else, and to be able to feed one's self.</p> <p>Socilaising with other people should be classed as something esential for everyday life, as being cut off can lead to depression and other health problems, like not caring for one's self properly and having bad personal hygiene, leading to infections etc.</p> <p>Basically, it would be anything that an able bodied person would carry out in normal day to day life.</p> <p>7) By taking accurate inforation at the start, liaising with general practioners, consultants and carers etc and by conducting regular updates on the person.</p> <p>I'm more than aware that conditions can fluctuate, as I suffer from Rheumatoid Arthritis. One day I can be fairly reasonable, although I do experience pain every day. But sometimes, I can be totally bed ridden as the pain, swelling and overall inflammation can be so severe that I need to be admitted to hospital. The fact that conditiona can fluctuate so much needs to be taken into consideration at the time the benefit is awarded. I experienced a medical assesment on my second claim of DLA and because my hands we ok and I could fasten my buttons, my care element was dropped. Yet if I'd been assesed on a day when I had high inflammation, it may have gone up!</p> <p>Just because someone is having a good day, doesn't necessarily mean they are like that all the time. MS sufferers can be exactly the same. Fine one day, and totally unable to do anything the next.</p> <p>Proper assesment, regular medical updates from health professionals would allow the benefits to be maintained properly without the need to be constantly filling in claim forms.</p>
ONLINE221	<p>3) Additional costs will, of course, vary with the nature of the health condition. Furthermore, circumstances to take into account might include such factors as location of home, suitability of home environment, availability of appropriate transport facilities, distance from place of employment, specific work-related problems, proximity (and accessibility /suitability)of retail, healthcare and social / religious facilities, etc.</p> <p>Extra expense can be incurred in various ways:</p> <p>1) Provision of aids and adaptations for the home. Examples could include such things as grab handles / rails, staircase handrails, stairlifts and hoists (including maintenance costs), modifications to washing or toilet arrangements, access ramps, specialist furniture (beds and seating, etc.), adaptations to kitchen equipment and work surfaces, widening of doorways, electronic door release and intercom installation, adaptations to home computer hardware,etc.</p> <p>2) Mobility aids and equipment for internal and external purposes. For example : manual/electric wheelchairs and scooters; Accessories, replacement parts, servicing / maintenance / recovery / insurance, etc for the foregoing items; walking frames and rollators, crutches and sticks, etc;</p> <p>5) Automatic entitlement should be invoked in certain specific circumstances, where the health condition is of an incurable, chronic or progressive nature.(For example: Progressive variations of Multiple Sclerosis).</p> <p>In order to save time and unnecessary expense for the Assessors, written statements provided by accredited specialist consultants or practitioners should be accepted by the DWP as sufficient case evidence to determine entitlement.</p> <p>This would have the additional highly beneficial consequence of limiting unnecessary worry and mental stress for the applicant, whose condition may well be adversely influenced by protracted investigations.</p>
ONLINE222	<p>?) I TYPED EVERYTHING OUT AND SPENT TWO HOURS ON IT BEFORE SUBMITTING THEM ALL. I SUBMITTED THIS ONE AND THE REST JUST BLOODY VANISHED. I HAD BEEN POLITE ABOUT IT AND MADE SOME USEFUL SUGGESTIONS LIKE USING CONSULTANTS RATHER THAN SO CALLED HEALTHCARE PROFESSIONAL. NOW HOWEVER I'M ANGRY AND HOW I FEEL IS THAT THIS ISN'T AND HAS NEVER BEEN ABOUT DISABLED PEOPLE. ITS A SOFT TARGET THAT THE GOVERNMENT CAN USE TOSAVE MONEY. THE CONSULATION PROCESS IS LONGWINDED FAILS TO ALLOW THE ISSUES TO BE ADDRESSED ALIENATES THOSE WHO NEED THE SERVICE MOST. THE DWP ARE INCOMPETENT AS ADMINSTRATORS OF WHAT THEY ALREADY DO, THE WHOLE</p>

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	<p>THING IS JSUT ANOTHER WAY TO EXTRACT MONEY FROM THOSE WHO NEED IT MOST AND DEFEND THEMSELVES THE LEAST. tHE CONSULTATION ONLINE IS FRANKLY RUBBISH!</p>
<p>ONLINE223</p>	<p>1) Discrimination - Most people with a disability will face some form of discrimination at some point in their lives. This could take the form of physical or verbal abuse, denial of services or denial of employment/education opportunities.</p> <p>Stigma - Even if someone has not personally been a victim of discrimination, the feeling of stigmatisation for being different may lead to them withdrawing from society.</p> <p>Lack of physical accessibility - Many places and forms of transport are completely inaccessible to those with limited mobility, whilst many more places have inadequate facilities for those with disabilities such as parking and toilets.</p> <p>Focus of services on self-care activities - Many services focus solely on an individual's ability to engage in personal and domestic self-care activities. This neglects roles and occupations which may be very important to an individual including their social roles and leisure activities. For example playing golf with friends may have been a valued occupation for someone prior to developing arthritis. Few services would have either the time or money to devote to helping this individual continue to engage in this occupation. The impact of this may be that the individual no longer sees their friends, thus losing valuable social support and becoming more isolated and withdrawn. This could impact further upon their mental health leading to problems such as depression.</p> <p>Access to work - Although employers have to, under the law, make reasonable adjustments to support disabled employees, many will find loopholes and dismiss or choose not to employ people with disabilities.</p> <p>Lack of flexible care packages - In most social services people are only entitled to four carers a day and these usually coincide with the necessities of meals, medication and/or bedtime. Most people cannot choose when their carers come and so are declined the choice of when they want to do things. For example someone may wish to have a lie in, but their morning carer may not be able to attend later than 8am. Or someone may wish to have help getting ready to go out for the evening but their evening carer may only be employed to provide dinner.</p> <p>3) Taxi fares - may not be able to access buses due to issues such as impaired mobility or impaired social functioning.</p> <p>Modified cars - cost of modifications and repairs for modified vehicles.</p> <p>Hospital appointments - time off work and travel/parking costs.</p> <p>Aids, equipment and adaptations - private purchase of aids and equipment not provided by social services such as dressing aids, bottom wipers, kitchen small aids, bathlifts etc. Also some adaptations to accommodation must be partially or wholly funded by the owner.</p> <p>4) An individual's level of mobility may directly impact upon their ability to carry out activities of daily living. This may lead to an individual basically being paid twice for impaired ability to engage in activities which is caused by an impairment in mobility. Also this could discriminate against those who have a disability caused by a learning disorder or a mental illness as their mobility may not be impaired but their ability to participate in daily life may be extremely impaired through other means.</p> <p>The term 'key activities necessary to be able to participate in daily life' needs to be defined. This may be very different for different people depending on their roles, interests and values. For example a mother may feel it is essential to be able to cook nutritious meals for her and her family, whereas someone else may be happy to live off ready meals. The phrase 'beggars can't be choosers' may come to mind, however it is essential for one's health and well-being that one is able to participate in the occupations that are personally meaningful to them rather than just the occupations another deems 'essential'.</p>
<p>ONLINE224</p>	<p>1) Strong, sedative medication for mental health conditions leaves people constantly tired and without the stamina to work, other than in perhaps a limited capacity. Mental health conditions are usually intimately linked with environmental stressors, so that again is a barrier to participating fully or at all in the workplace. Managing a long term chronic condition takes a huge amount of energy and effort that people in good health have available instead for participating fully in life - and take for granted.</p> <p>Unfortunately the government is choosing not to redress the underfunding into mental</p>

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	<p>health research that could improve this situation.</p> <p>What i've read so far in the consultation about changed attitudes due to equality legislation - if only it were the case!! how deluded. of course it's had a positive impact, but there is still huge stigma to address, no minister could deny this. stigma against all disabilities are a huge barrier to preventing people participating in society, etc.</p> <p>Physical limitations and what people can mentally and emotionally cope with day to day - again the problems and barriers faced by people with disabilities.</p> <p>2) The security people feel on a long term benefit such as DLA is absolutely crucial. Where a disability has reduced a person's options and chances in life, and certainly is a huge financial burden, the last thing someone this vulnerable needs is constant worry and anxiety that a crucial financial support will be whipped away from them at any moment.</p> <p>3) A very restricted, if any, capacity to earn.</p> <p>6) Being able to work should be high up on the list of key activities necessary to be able to participate in daily life. For those of us who work, it provides a livelihood, income and social inclusion and interaction, and structure to our days.</p> <p>7) A mental health condition, for example, can be episodic, with times of better functioning interspersed with serious episodes of illness and long recovery times (months, even upwards of a year). The assessment for the benefit should not favour those with a stable, unchanging condition over those with an equally serious condition that is episodic in nature. An episodic condition can be harder to manage and has to be treated as though relapse can occur at any time (which it can). The assessment absolutely must have regard to this, otherwise it would be discriminating against many with mental, rather than physical disabilities.</p> <p>9) It should be absolutely clear that entitlement is just as much for mental as physical disability, there must be no slant in favour of either.</p> <p>10) It is very important that evidence comes from the individual and any professionals involved in their care. The assessment should NOT be left up to professionals who have no involvement in the individual's care - if it were, this would likely lead to a harsh assessment without proper insight into the day to day difficulties experienced.</p> <p>11) This sounds like it could be a very stressful and negative experience for the individual, and a costly way of administering the benefit.</p> <p>15) Entitlement to the benefit should not be linked to forcing claimants to receive help they may have received in the past and decided was not for them, or intimidating them in any way to take a course of action they would not choose. This is saying that a disabled person has less rights and freedom to choose their own lifestyle than anyone else, which is entirely draconian, unfair, unkind, inhumane and undignified.</p> <p>?) It is very good that DLA passports to disability tax credit, as this is additional income where a disability means that an individual can work, albeit not in a full time capacity.</p>
ONLINE225	<p>1) there are numerous problems and barriers preventing people with disabilities participating in society and leading independent, full and active lives; - alongside a most important principle that there are numerous reasons why people with disabilities are able to participate in society at different levels than people who have no disabilities - dependent on their individual disability.ie their levels of independence, and fullness and active lifestyles are completely different from that of people without learning disabilities.</p> <p>This is especially the case for people with learning disabilities as they face difficulties through out their lives with language and communication - in speech, and understanding and reading words and figures, in physical health issues,in mental health issues, in concentration levels, in levels of cognition and memory, in mental capacity, in ability in making their own decisions, in vulnerability in being taken advantage of by other people, in ability to work in any workplace, in fatigue and poor attention spans - these factors are especially the case for older adults with learning disabilities - who tend to tire more than normal, and age more quickly than normal, and cannot cope easily with any changes in daily routines</p> <p>2) any new benefits should be able to be used by the recipient to enable them to lead as independent and full a life as possible - in supporting care, mobility, housing, rent and utility bill costs - in supported living schemes enabling people with learning disabilities to lead as independent and full lives and possible in the community and participating in society as able</p> <p>3) extra costs people with disabilities face include: no other finances available to the individual - so benefits cover all aspects of daily living including foods, accomodation, support charges, rent, supported living providing car</p>

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	<p>transport to day centres, and for transport to social activities and shopping in the community; quality of life - chiropody, prescriptions, dentist, optician, and other health appointments, special footwear and clothes, special transport - for access, equipment costs - hoists, chairs, beds, wheelchairs, ramps, toilet access at home and in community, bathing access.</p> <p>4) no difference whether 2 or 3 or however many rates in understanding and administering the benefit</p> <p>5) there should be consideration for certain health conditions and impairments being entitled to automatic entitlement to benefit - for example for people with learning disabilities from birth - with severe disabilities including Downs syndrome - when the individual is likely to experience severe restrictions in abilities, mental capacity and levels of independence throughout their lifespan - with no likely improvements in abilities and disability is lifelong from birth for these people and they are unlikely to be able to work and earn a living wage unlike normal people without disabilities - and they are likely to need support from others in work and social activities and all activities of daily living - throughout all their lives from birth to death</p> <p>6) dressing and undressing preparing meals and drinks bathing and washing washing clothes self care, hair, nails, general appearance clean and tidy home communicate - speak and listen and understand spoken and written words ability use telephone ability understand money ability do appropriate shopping social life and contacts ability to go on a journey and plan ability to walk and do stairs and slopes - indoors and outdoors ability to be involved in community mental health status physical health status access to appropriate transport to travel to required destinations in the community vulnerability - mental capacity - road safety</p> <p>7) assess the individual on a number of occasions include full consultation with health and social care professionals who know the individual include an assessment from appointed Deputies for personal welfare by the Court of Protection when in post.</p> <p>13) appoint someone to act for / on behalf of the individual for example appointed Deputy by Court of Protection - as not everyone with a disability has the ability to identify and report any changes in their needs - they need an advocate</p>
ONLINE226	<p>1) Finance, personal care, tiredness and capability of working. Additional costs for care, continence, mobility. These costs can still apply in residential care and are not covered by care homes or social services care plans.</p> <p>Public transport is not yet fully accessible, so private vehicles are still needed. When public transport is available, more expensive power chairs are needed, because less expensive mobility scooters are not generally permitted on trains and buses. Many users do not have power chairs. Until scooters are allowed on public transport power chairs are the only option. These are much more expensive than scooters and require a hoist if to be carried in a car. These options are only affordable with DLA/PIP and do/would greatly increase independence, quality of life and full participation in society.</p> <p>2) Long term disability/illness should still be automatically awarded to conditions named in the DDA/Equality Act definition of disability. Many claimants have a DLA award letter which says for life. Normally, changes affect only new customers, not current customers. It should continue to be long-term for those who qualify, e.g. a congenital disability, MS or Parkinson's which is not going to go away and if anything will get worse. This will save money.</p> <p>PIP should continue to be available to disabled people in residential care. This could be individually accessed with a different rate, if appropriate, but the current £22.30 p.w. will not cover mobility needs, as well as other disability and non-disability needs. Care plans do not include personal mobility. Residential care will become a prison for many disabled</p>

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	<p>people if support is not given.</p> <p>Short periods of 28 or more days hospital or residential care may not affect the needs of the disabled person long-term, and may not provide savings on costs to the government overall, so payments should continue. In particular, a Motability Finance lease or loan is a binding legal agreement that must continue to be paid during these days, in the same way that the council tax, phone rental, energy standing charges, broadband contracts, etc. still need to be paid throughout such periods.</p> <p>There is a danger that the changes will be more confusing. It is not clear yet how the government intends to carry out the reviews for new or current DLA/PIP users/applicants. The change in indexation from RPI to CPI makes the DLA/PIP less favourable.</p> <p>3) Shoes, alternative therapies, exercise, heating, mobility aids and maintenance thereof. Insurance, transport door to door and personal care, cost of other family members taking on a responsibility that the disabled person cannot do i.e. housework, house maintenance, decorating and gardening. They may need a buddy or a volunteer and their costs need to be covered.</p> <p>Expectations for disabled people have rightly changed since the mobility allowance was created, and even since the DLA began. Disabled people are covered by UN, EU and national equality legislation, and technical and cost changes, providing more goods and services for disabled people, means that mobility and care is easier if finance is available.</p> <p>4) Will it cover everything? The mobility element currently only has two levels so presumably no change there. More levels would provide more individual needs and residential care might require a lower mobility level than previously received, rather than the proposed no benefit for those affected, but this is much better than no benefit. Having just two rates might not cover everyone's needs i.e. those on level 1 on old system might not meet the new criteria and so not be entitled to anything.</p> <p>5) There should be automatic entitlements where appropriate, particularly for lifetime conditions. It is a waste of resources and an unnecessary worry to keep assessing everyone.</p> <p>Is the 6 month wait from applying for PIP going to apply to those now on DLA?</p> <p>6) To enable financial assistance to purchase aids etc. to be able to function. A disabled person having, for example, a power chair or scooter is only putting them on a more equal basis with people who can walk, but the solution costs a disabled person a lot of money. When the mobility allowance first started, society's expectations for disabled people were very different to today with little legislation or equality. The PIP needs to reflect modern needs and expectations. We strongly support the promise here to make sure life is <math>\text{€}\square</math> and active <math>\text{€}\square</math>.</p> <p>Shopping, work, social activities e.g. clubs, holidays, hobbies, independence and mobility.</p> <p>7) It should rely on the disabled person's own healthcare professional to give an in depth report on their condition. There needs to be imagination, and an expectation that disabled people should have a full life.</p> <p>Remember that all DLA recipients receive a letter around March noting the annual inflation adjustment, plus a letter in December for the annual £10 bonus, reminding users to update their circumstances when they change.</p> <p>8) Yes, but they should not be used against an applicant. The increased need for new products and the provision of the DLA to help purchase them has encouraged manufacturers to provide lower priced (although some still very expensive) and better designed products, creating a whole new industry, a benefit for the UK, as well as disabled people increasing independence and freedom.. This should be acknowledged and the PIP should encourage this growth.</p> <p>Any aid or adaptation is part of an overall package and just because you have one aid does not mean that you no longer need the benefit for the purchase and maintenance of any aids. Also continence items and housing adaptations should be included.</p> <p>Yes, as long as this is seen as an aid not a way of taking someone off the PIP. It should take into account both current and future needs. The reviewers/interviewers should have medical and care experience and knowledge built up as they do many visits and should be able to recommend additional services and products that the PIP could provide to increase the disabled person's quality of life and independence. He/she should have local and wider knowledge of what is available and would be of benefit to individual disabled people.</p> <p>9) Shorten the number of questions and not focus on things the disabled person can't do. Phone line support, internet use, including interactive forms, on-line videos with BSL explaining the system and giving examples of qualifying and benefits and allow the use of</p>

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	<p>tape recorded applications.</p> <p>Advertise, social networks, online and as above emphasising the changes in welfare payments stating that PIP is not means tested and you can also work and claim it.</p> <p>10) A report from a health professional who knows the disabled person would be useful. Although GPs can assist, with group practices patients are less likely to have a single long-term family doctor who has known them over many years. The applicant is the expert in his/her condition/need and this should also be acknowledged. A person's own carer could also provide evidence. A home visit would show the full need in context and be less intimidating or tiring for the applicant.</p> <p>11) Face-to-face is more human, and the needs of the individual better explained and observed, which a form cannot show.</p> <p>The condition may not be apparent and may need expert medical opinion. There is a risk of infringement of privacy, especially with intimate and personal questions.</p> <p>There could be inconsistencies with the review. The disabled person may need to take time off work for a home visit or to travel to the interview. They could be concerned about the process and outcome.</p> <p>We note that many organisations and individuals have expressed their feelings and concerns on-line about using Atos Origin and their software in other benefit reviews, and we are concerned that this method and company may be used for the PIP. Lessons need to be learnt from the Atos experience.</p> <p>An advocate or mentor should be able to accompany the disabled person, especially if the person has mental health problems or learning difficulties. Someone with communication issues might need an interpreter.</p> <p>12) Depending on their condition €“ if it is one that is not going to get better the reviews should be infrequent and there should be lifetime awards where appropriate.</p> <p>There needs to be real understanding of disabled people's needs.</p> <p>Yes, mental health or learning disabilities may need different requirements to a physical disability.</p> <p>13) The annual update and Christmas bonus letters always remind DLA users to report any change, and that should continue. There should not be punishments unless very clear fraud. Forgetting to mention a minor change, for example, should not be punished.</p> <p>14) To make clear eligibility, give some suggestions and ideas for what it could be used to pay for.</p> <p>15) Yes.</p> <p>Perhaps in GPs or at other local places that give advice as in libraries or local authorities where care packages are negotiated.</p> <p>16) Yes, because at the moment to fund adaptations it comes out of the disabled person's own pocket, or from charitable donations. The PIP could pay for one-off costs like a new scooter/power chair/manual wheelchair, and on-going costs of maintenance, servicing, repairs, insurance, replacement, etc.</p> <p>17) N/A €“ we have no experience of this.</p> <p>?) Access to work/social worker/occupational health could be done by one person and shared. However linking information up may allow for more mistakes.</p> <p>Some people do get Social Services Care packages, but as with residential mobility costs, tight local authority budgets may mean that disabled people don't get what they need. The PIP needs to take this into account in each case.</p> <p>?) It would make it far more difficult to prove disability and claim other concessions as this may be the only benefit some disabled people can claim as it is not means tested. You would end up with a lot of duplication which is not cost effective and might also have a detrimental effect on the person being assessed over and over, having to forever explain what they cannot do.</p> <p>?) If not carried out fairly could disadvantage disabled people.</p> <p>?) It is linked to many other concessions i.e. Blue Badge scheme, disabled rail card, free bus and companion bus pass. Some local authorities may also add to this with taxi tokens, leisure centre discounts etc.</p> <p>?) Will there be a break in payments if successful on PIP and you have successfully claimed DLA? Claiming DLA gives access to other benefits, will these still be able to be claimed? How will the new measure affect the Motability car scheme will it honour current contracts?</p> <p>Some of the cost will be paid for in enabling disabled people to participate more fully in society, encouraging higher disabled employment levels (even though the DLA/PIP is not</p>

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	<p>directly an employment benefit, care and transport needs can be part of the need). This leads to greater independence and disabled people paying more taxes, buying more products and services, staying in their own homes, which is much cheaper and better for most people. This could mean they need less of other benefits if the DLA/PIP opens up better employments opportunities.</p> <p>There is nothing about an appeals system. Appeals must be timely and easy to follow. Payments should be back-dated to the rejection date when an appeal is successful.</p> <p>The Disability Living Allowance and work: Exploratory research and evidence review, 2010, DWP Research Report No. 648 (RR No.648) evidence does not give clear indication that the DLA needs to be reformed. We are concerned that replacing it with the PIP may mean many disabled people will lose out on a much needed benefit and stopping it for those in residential care for over 28 days will mean that older and more severely disabled residents will become prisoners in their residential homes.</p>
ONLINE227	<p>3) I am responding as I wish to express how much DLA helps my husband and consequently myself.</p> <p>I work for the DWP (and have done for 34 years) as a Band B earning approx £20k pa. My husband has multiple illnesses and disabilities for which he currently receives Incapacity Benefit and DLA low care and low mobility.</p> <p>The 3 main extra costs he / we incur due to his disability are: electricity / gas - he is home all day and has poor circulation so our domestic fuel bills are very high; phone calls - each week he has to make numerous calls to arrange / confirm various medical appointments, so our telephone bill is very high and lastly: transport costs - he can drive but is no longer able to drive very far. I do not drive. Therefore we incur taxi fares / public transport costs when we have to go somewhere and he is not able to drive, whilst we still maintain the cost of running a car - which we cannot always use.</p> <p>All these expenses are higher than the costs we incurred when he was able to work. So not only have we had a reduced income due to his disabilities by the loss of his wages, we also now incur domestic expenses that are higher than they were when he was able to work.</p>
ONLINE228	<p>1) Disability is fairly new to me. Age 47 I developed epilepsy and between then and now (60) I have developed various other 'disabilities' including spinal problems. I wear a full length caliper because of unsuccessful surgery. Not only do these things give me physical problems but the 'knock on' problems of medication I need to take. Disabled people are as vastly different as non-disabled people - we can't all be 'lumped together'. We have our own barriers that that stop us from participating in society and leading full and independent lives and then there is society itself. On the whole we are a nuisance. We take up more space, more time, more understanding. Sometimes I meet a shopkeeper, taxi driver - put whatever name you like there who will be genuinely helpful treat me exactly the way I was before I became slow and confused on opoids and anti-convulsives and in a wheelchair. We treat each other with mutual respect have a laugh together and for a brief moment I am just ME again. I think you know what the barriers are : peoples attitudes - these have not been helped recently by the Government continually 'attacking' disabled people and planting the idea into the minds of the public that all disabled people are scroungers and lazy layabouts who could be working but would rather be living off the state. Believe me this really has happened. Also physical barriers. One small personal example - I lost my driving licence when I developed epilepsy. My physical problems now mean I walk a very small distance on a good day or use a wheelchair. I live in a cul-de-sac. The pavements are such that I cannot possibly walk on them, nor indeed wheel independently on them. Despite the fact that myself and others asked the council to take this into consideration when they were resurfaced recently no-one cared about the high rates we were paying nor the fact that disabled people would be treated less than equally In effect, this makes me house bound unless someone takes me out in a car - or put another way I am a prisoner in my own home at the grand old age of 60! I recently went for a weekend away with my husband (we have not had a holiday in 13 years.) Despite asking for wheelchair access and a wet room, there were no hand rails anywhere, not even in the shower! When asked about this the owner could only say 'put any complaints in writing'. This I did and he did not even give me the courtesy of a reply. To hear you talk about a 'social model' makes me wonder wether to laugh or cry. Are you living in the same world as me and thousands of other disabled people many of whom are vastly more disabled than I am. A lovely young lady assistant in Boots Chemist helped me to do some shopping just before Christmas.</p>

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	<p>When we had finished she said 'I can't believe how rude people are to you in a wheelchair, how do you put up with it?' I do my best to keep myself as healthy as possible within the set of given circumstances I find myself in. I try to eat healthily and I try to do what exercise I can which is very limited. My physiotherapist recommended that I attend a seated exercise class at least once a week. Despite my best efforts there was not one in my home town. The nearest one was in a village requiring a round trip of 16 miles. Not only did this mean I had to find someone to take me I had to pay for their petrol. Also because I was not a resident in that area I had to pay more than double for the class and four times as much per year for membership to the leisure centre. I have spent about two years writing to my local leisure centre requesting something locally. I eventually started a class just before Christmas but this will closed after a few weeks because they said there is not enough demand. I really am a tremendously positive person - believe me I would have given up by now had I not been, but it is so hard not to believe that the whole world is against us most of the time. Sorry, but I don't think that all the medical models and social models in the world are going to enable disabled people to lead full and active lives and participate in society. You are starting at the wrong end ie with disabled people by turning their already traumatised lives upside down yet again rather than trying to educate non disabled people and policy makers and doing something to make our lives LESS stressful. So, we have the barriers caused by the attitudes of society and physical barriers which COULD be changed but often if they are changed by law it causes resentment therefore defeating the object. This brings me onto financial barriers which many disabled people face - I accept this is not limited to disabled people but I have never felt more vulnerable since becoming disabled.</p> <p>What else stops us participating in society? Shopkeepers who see people in wheelchairs as a nuisance and leave piles of stock, stools, boxes and anything else they can find to make it impossible to go around a shop, cars parked half on pavements making it impossible to 'wheel' or be wheeled down a street, I could fill a page up with this sort of thoughtlessness. Lack of appropriate parking. What use is a blue badge if there is nowhere appropriate to use it? In my town there are two places to park next to the centre shops. These can actually be used with my blue badge before 10am (except market days) and after 4pm. Try my drug induced sleep (or sleeplessness) then 90 minutes it takes me to get ready + getting to town + getting wheelchair out what time do you imagine is left before 10am? Same goes for 4pm when shops close at 5 - 5.30? I can't dash around like some fit young thing. Would you not feel they are saying 'I know we have to throw you something, take these bits when you can't inconvenience anyone. If on a rare occasion I would like to go out for a meal it is impossible to find somewhere to park without having to be pushed for a long time in my wheelchair and half freezing in this cold weather.</p> <p>The university in the town where I live is one of(if not the) largest in England and is admired for it's facilities. It is having all sorts of additions made to it for the 2012 Games which is wonderful and I am proud of that.I know many other places are having huge amounts of money spent on transport links for the games to name one thing. However, I am not able to use my railway station without requesting to be taken over a barrow crossing by a member of staff as there is no lift over the line which is served by a bridge and stairs. In addition, to this it was decided to redesign the ticket buying facilities. Instead of being able to buy a ticket and go into the waiting room or under the covered platform you now have to go back outside and through a mechanical barrier - a nightmare for anyone on crutches, in a wheelchair, sight impaired or with many other disabilities. I already found using the station an undignified experience but the first time I used it with that in place (even with a BR employee in attendance who was very rude to my son who was trying to help me) totally put me off using it again and I have not travelled by train since. There seems a huge imbalance here.</p> <p>When I was working, it was a long hard slog to get a job when I first became disabled even with good qualifications and having worked hard all my life. I was actually given a job with the Civil Service. However, for some reason that never became clear everyone who had been accepted on the same day as me started six months before I did and I had to spend that time continually 'phoning and trying to find out what was happening despite the fact that at that time no particular adjustments had to be made. My entire time there was almost unbearable and looking back I wish I had taken things further but I was never one to make a fuss. The only good thing to come out of it is that I made some really true friends. Social models are all very commendable but the phrase 'you can lead a horse to water ..' springs to mind. My employers had all sorts of policies in place but at the end of the day deadlines</p>

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	<p>and caseloads were what really mattered and human nature is such that when a department is very busy everyone needs to be seen to be doing an absolutely fair share. However hard you try when you are on certain medication and/or in pain it is not always possible to give 100% all of the time. I mentioned the social model and I must also say something about the medical model. Fix the body and then participate in society like everyone else? Unless you can perform a miracle I am not sure what you are thinking of. I take anti-convulsants for epilepsy - they may have stopped some of my seizures but at what price? My mind is dulled, I have been trying to write this reply since 4o'clock this afternoon and it is now 10o'clock at night because I struggle for words and I cannot stay in one position for long. I am constantly sleepy and sometimes confused. I take two different tablets for osteoporosis, They create gastric problems and dental problems. I use three different sorts of drops for my eyes. One to reduce pressure has caused another problem so sometimes they are so red and swollen I have to use sunglasses during the day. Two tablets for high blood pressure, yes they reduce my blood pressure but cause tiredness to the point of complete exhaustion. Opioids, plus other blanced medication for pain relief they help the pain but again at what price, sometimes I feel almost as if I am in another world with the combined effects. I could go on but you must be getting the message by now. I wear a full length caliper on one leg, it may help me to stand on that leg but it also makes my leg swell to the point where I have to undo the straps so it doesn't cut into me. It rubs my skin, makes it sore. The caliper put strain on the rest of my body so I now wear a brace on the other knee plus an insert in the shoe. The prognosis for my health is not good and my future terrifies me in case I can't live independent!</p> <p>2) whatnext08 responded:  There are as many variations of disabled people as non disabled people. I shall be retiring in a couple of months time so there will be financial changes for me anyway. I mentioned in the previous question that I have never felt so vulnerable as when I became disabled €“ your statement Individuals who receive the benefit before reaching 65 may continue to receive Personal Independence Payment if their needs continue is typical of statements that are made that make me feel vulnerable. What does may mean? How long can I rely on that? How can I be expected to budget with that terminology? Can you understand how that is frightening? However people respond I think your minds are already made up but I would plead with you to please STOP making people feel so anxious about what is going to happen to them, give us some credit for being intelligent, credible people even though we may be a bit slow and foggy at times.</p> <p>Another day and having thought about that some more, younger people of working age must also be feeling anxious about the references made to work. If I look back to how I felt when I first became disabled I struggled on for as long as I could (and far longer than was good for either my physical or mental health) to stay in employment. Despite the myths that are floating about I think the majority of disabled people do try to work if at all possible. Ok there maybe some people who are bucking the system but don t let that cloud your judgement against all disabled people. I do think DLA, whatever, it is called, should stay a benefit totally unconnected to work. Disabled people worry enough about the various implications of benefits and work without this becoming another one that is being held over their heads as a potential in work benefit. I think too, that it should remain non-taxable. It is given to pay for the expenses of being disabled which is a fixed sum for each disabled person tht does not change €“ there is a place for taxes and I don t think that is DLA or PIP.</p> <p>3) whatnext08 responded:  Like many disabled people, I need far more heating than the average person. I can t move around as much to keep warm, some of my medication makes me feel cold and my circulation is poor.</p> <p>Again, like many other disabled people I can t drive because of disabilities so have to rely on a family driver or</p> <p>use taxis as I cannot use public transport. This means the family car always has to be bought with my needs in mind €“ wide opening doors and high seats to accomodate my lack of movement €“ plus room for wheelchair in addition to normal daily needs. This all adds to cost that would not normally have been expected, especially at our time of life (we had already downgraded and had to change to a more expensive car)</p>

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	<p>Clothes and shoes to fit and take the hammering that calipers and other such aids give to clothes. It is very difficult finding things to fit anyway only to find that they have a short life because of all the rubbing and trapping they get in straps and clips and metal rods. If you buy clothes from special disability shops they immediately have a large supplement on them just because they are labelled disabled. The same goes for equipment. When I bought a helping hand the one in the disability shop had a mark up four times that of one someone found for me in a non disability shop! Trying to buy anything for a bit of comfort or help is a nightmare financially. There seems to be an assumption out there that disabled people have a bottomless pit of money from somewhere to satisfy their every need. Trying to find a bathroom suitable for a disabled person is easy if you have several thousand pounds to throw at the problem. If you own your house and become unable to use a bath then you simply have to get used to having a chair wash until you somehow manage to put together your own package to get a seated shower put in, if you are lucky with the help of a talented husband. How others manage without getting into massive debt I don't know. The same goes for a manageable kitchen. There are some wonderful kitchens out there for disabled people, again if you can throw thousands of pounds at the problem. I have not sorted out that problem yet.</p> <p>That leads me on to food. If you cannot reach hobs, cookers and carry hot dishes safely you are limited to what you can cook and eat. We are constantly being told to think about what we eat and to eat healthily. I used to love making healthy soups and casseroles and vegetables and pasta dishes. I am intelligent, adaptive and creative but even I have been pushed to my limits to try to create cheap, nutritious dishes in a kitchen I physically can't work in and with my disabilities. If I eat healthily now it is definitely far more expensive but more often than not I don't eat healthily. The DLA care allowance I receive acknowledges I am not able to cook a hot meal for myself but I get less than £19 week to cover this and some daytime care.</p> <p>My husband and I have worked hard all our lives both in full time employment and bringing up our children right through university education and into successful careers. By now we had hoped that we would be enjoying our retirement together. I am not bitter that I have become disabled but I do feel sad that through no fault of my own our lifetime of careful planning for the future has been lost and I am in a position where I have to rely on my husband not only for care but also the whole running of the home and garden now falls on his shoulders. He, too, although not disabled, is not well and it saddens me that he has to do the housework, shopping, gardening, washing etc etc as well as taking me and himself to the endless doctor and hospital appointments in several different towns. We are wondering if we can use some of the meagre DLA I get for help in the house but it is all so uncertain. Not only are you planning to spend large amounts of money on restructuring DLA, but as I said before, for my age group, whatever it is called, it is a maybe anyway. Really, whatever you do, or wherever you go, you usually end up spending more because of your disability. We have not had a proper holiday in 13 years, but a recent weekend away was ruined because although we had booked a cottage with disabled facilities, there were no handrails anywhere!!!! Not even in the shower €" nor was there a seat! The owner told me to put my suggestions in writing, which I did but he did not even send me a reply! This was after paying extra for a disabled cottage ! (Your Social Model is up against an awful lot)</p> <p>I suppose you could say that with my age and disabilities I should be thinking about moving from our old family house that is hard and expensive to look after, clean and for me to get about in. However, you try selling a house like ours for the the money it is worth to buy a modern, manageable bungalow in the present financial climate. Then there is the upheaval itself and if one cannot be found near where we are now, having to change familiar doctors, and ancillary carers and medical carers €" it is actually quite a nightmare financially and every which way. Added to that is a terrible lack of the sort of accomodation that would be suitable as it is sought by elderly and disabled people alike.</p> <p>4) whatnext08 responded:  On course reducing the number of rates would appear to simplify the understanding and would obviously simplify the the administration €" it is the ensuring appropriate levels of support that would be in question here. I agree that in the past the three levels of the care component have caused great upset with many people who feel that they have been unfairly assessed. What I am not sure about is what can be done to overcome this problem. I guess what will happen is that many people on the lower rate care now will lose it altogether (which is where the saving money will come in) and some will be justifiably</p>

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	<p>moved to a higher rate of care which is where they should have been all along. Winners and losers €“ but who is going to make that decision and are they the right people to make it? I get a scary sort of feeling that some people are going to be pushed out into the cold as not quite disabled enough . What happened when all the psychiatric hospitals were closed down? One day people were regarded as sick and in need of care, the next, turned out as capable of looking after themselves.</p> <p>If you think about the vast range of disabilities and needs I really am not sure that two rates per component could fairly cover every combination of needs. I think that what would happen is that many people would tend not to quite qualify for the new lowest rate therefore enabling another layer to be removed from benefits.</p> <p>5) whatnext08 responded:  However it is done, claiming benefit and having to fill in countless forms and sometimes undergoing yet more medical examinations, is extremely stressful and tiring at a time in one s life when stress and exhaustion are being heaped on you in large doses anyway. I feel that if it is possible for some people to be spared this by an automatic entitlement to benefit then that it all to the good and I do not see how anyone can object to this. I don't think I am qualified to give an opinion as to what these conditions or impairments should be.</p> <p>6) whatnext08 responded:  Unfortunately it is not by taking money away €“ people least able to lead full and active lives are no different to the people who DO lead full and active lives, they just need more help, support and facilities to get on with it. Sadly, either through ignorance, lack of finances or sheer thoughtlessness it just does not happen.</p> <p>YOU get up in the morning, shower and dress yourself, drive yourself, ( or independently travel) to work, perhaps enjoy a social hour at lunchtime or after work. At weekends you can go for a walk or to your local leisure centre and enjoy a work out or a swim or a class of your choice. I have to see if anyone will take me out because I can t get out of my street. My leisure centre doesn't offer any class that I can participate in. My hobbies used to be cooking, sewing, gardening,walking,reading, bird watching, shopping, socialising, etc. It is just accepted now that I can t do these things €“ tough. I try my hardest to keep in touch with old friends and make new ones but it is hard work, we lead different lives now. Just being normal is essential to everyday life €“ but for that you need access to trains and decent parking, (see answer 1 ) not just in London but everywhere. You need the money to pay for petrol to be able to go out and to be able to stay in a decent disabled friendly room once in a while. I don t know what the answer is €“ it s not my fault the country is in such a mess €“ it s not my fault I became disabled €“ it s not my fault so many other people are disabled and suffering €“ how ARE we able to lead full and active lives? The main point is though that the activities disabled people consider essential to everyday life are just the same as the ones that able bodied people consider essential to everyday life.</p> <p>7) whatnext08 responded:  I think I have probably answered that question further down the page €“ briefly the best person/people to dcide this are those closest to the claimant ie GP or specialist. It really cannot be done in one appointment by someone who does not know the true FULL everyday problems of the claimant</p> <p>8) whatnext08 responded:  I think you need to be very careful here. On the one hand I can see the point you may be getting at that some people may use many aids and adaptations and become very independent and proficient whilst another may use nothing and stay completely disabled . However, there are several points to bear in mind. For instance, I wear a full leg caliper following problems after surgery. Although it helps me walk a little bit, it is very heavy so gives me problems with my hips,back (which I already had problems with anyway),knee on the other leg so I have to wear a knee brace and makes my leg and foot swell. I know some people leave them off because of these problems and just use a wheelchair all the time and I don t blame them, but I like to try to walk even if it is a few steps every day. Everyone is different, which is why I said at the beginning you need to be very careful. Who is to decide if I am wrong to take it off in the summer if my leg swells and the straps cut into me? Who to decide if I am right or wrong to take off the knee brace if those straps cut into me and I can t wear it any longer? I sometimes wheel myself in the wheelchair but I also have problems with painful joints in my fingers and shoulders €“ who decides when I should wheel myself or someone else should wheel me?</p> <p>It doesn t really matter what is included as long as you remember that sometimes it is not</p>

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	<p>possible to use them even if they are wonderful one day they may be hell the next. It depends why the person hasn't got an aid as to whether they are considered or not. It could be that a particular aid has been considered for someone and rejected for a good reason – on the other hand it could be that it has been overlooked and would be really helpful for that person. Again each person needs to be treated as an individual.</p> <p>As far as the wheelchair goes, I personally would not regard myself as independent and leading a full and independent life when I am in the wheelchair – far from it. On a good day I am unable to wheel myself for longer than a few minutes, then there are all the physical obstacles. Also as with anything mechanical, chair, caliper, knee brace things go wrong with them – big and small putting them out of action from minutes to weeks which totally alters life and how you live it. Another point to bear in mind is when people became disabled. If someone has been disabled since birth for instance, they are likely to be much more used to their disability and ways of getting around etc. Whereas when disability has come later in life it can be harder to get used to these things and as you get older you are probably having to cope with more than one problem and things going wrong as time goes on.</p> <p>9) whatnext08 responded: To be honest, my memory is awful and I cannot remember the questions on the form. All I can remember is that it was really long, I found it quite stressful, and it took me several days to fill it in. I think I would be better leaving this question to people who have filled one in recently! You can improve information about the new benefit by just simply being clearer and open about it – why should people be made to feel uncomfortable and stressed about this benefit? People claiming other benefits don't feel they are being watched and interrogated which is what I have heard a lot of disabled people complaining of. People know what it is for and who qualifies, from what I can understand it is the unfairness of who gets it and who doesn't that is in question.</p> <p>10) whatnext08 responded: Whilst a healthcare professional of any kind could get some sort of idea of a person's circumstances in a one to one interview, they are going to have to be done by someone who the disabled person trusts. As I said before I was lucky in that I had a good experience with Atos but I do not know anyone else who has. Atos is now regarded as doing anything they can to disbelieve the person involved and refuse benefits. It has to be done in a much more professional way with more emphasis being put on the GP's, physios, or other professionals opinion. I believe too, that in the past there have been many cases of people whose illness/disabilities have been totally misunderstood by the person interviewing them because of the nature of the illness/disability. Many people have more than one condition or complications of conditions caused by medication or other things which are not always understood or totally ignored resulting in them losing or never receiving benefits. This is very frustrating and upsetting. Whoever provides evidence or does the interviewing you must always ensure that SOMEONE who knows the person very well is included in the process and that their voice is given full value. As an example, I think my GP knows more about my general all round health and effect of the medications I am taking even though they are for a wide ranging number of problems - whereas my orthotist has much more idea about my leg and foot problems and the knock on effects they are causing, thereby knowing my abilities in this field.</p> <p>11) whatnext08 responded: A lot would depend on who the healthcare professional is. I was fortunate that I had a very understanding doctor when I went for my medical. He was understanding, thoughtful and very gentle. I believe from many people that I was exceedingly lucky. If the professional is appropriately trained to talk sympathetically to that person about their particular condition then hopefully it should work ok. If not – I dread to think what could happen. Can we really believe that each case will be appropriately linked? I can also see problems if someone is alone and required to see someone they don't know either in their own home or somewhere else, that would be unreasonably traumatic. There are also various illnesses where it would be inappropriate to ask people to see a stranger and be required to answer questions. It would be inappropriate for someone with a terminal illness to undergo a face to face meeting. I don't really feel able to answer this question fully but I am sure that there are other conditions where it would be inappropriate and unkind or unfair to ask people to do so and I am sure other people will point out what these are.</p> <p>12) whatnext08 responded: If it is going to happen then it seems reasonable that reviews</p>

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	<p>are built in rather than people drifting the way they do now. If people know what is going to happen then it becomes part of the award and therefore less frightening which is what is happening at the moment. It would seem reasonable to decide at the beginning of someone's award to let them know when a review will happen. However, There are some disabilities/conditions that really are not going to get better or change however much time changes or however many aids someone uses. In these cases it really does seem a waste of money for the government and unnecessary stress for the person to have frequent reviews just for the sake of it. In these cases an absolute maximum of reviews every 5 years is probably too much. On the other hand with a disability or condition that is changeable or can improve with time/medication/ or some other treatment then it is not unreasonable to have reviews every year. The point here as with so many other things is that the person's GP/specialist is likely to have a pretty good idea which group that person is likely to fall into much more than a doctor who is seeing that person once and has absolutely no idea what kind of life that person has or what he/she is putting up with every day and night of their lives.</p> <p>Also I have been hearing the experiences of people in the past few months who are stressed out of their minds after a review that has been carried out by a 'doctor'? from Atos in a most cavalier manner - they have then been turned down by a decision maker after they have been on incapacity benefit and DLA quite legitimately for years - and been left still disabled (nothing has changed for them) with no money nor support. They then have to fight their corner at a tribunal and more often than not get their benefits reinstated and often upgraded. Is it right that people go through this. What can you do to ensure that they don't? I know a few have been caught cheating the system but I have heard of far more being cheated out of their rights and being put through hell. Please believe me when I say that I am not denying there may be a problem sometimes but surely the very least we deserve is a qualified doctor who is earning a salary for a job done honestly and impartially - not unqualified anybody's prejudiced by whether they will earn any money or not. Do you actually know what is going on, because if not try reading some of the disability websites and see how genuinely distressed some REAL disabled people are who feel as if the rug has been pulled from under their feet.</p> <p>?) I have found this consultation document VERY difficult to complete and it has taken me weeks to do it. Even now I have not answered all of the questions but I am exhausted and do not have the energy to do any more. I think if you wanted ordinary members of the public to take part you could have made it easier to do. Many disabled people are on a lot of medication that makes them feel tired and confused - added to that we lose a lot of sleep because of pain. We have problems filling in all sorts of 'forms' that might seem fairly straight forward to you. I wanted to make some contribution so I have filled in what I can. All I am asking is leave us some money for a dignified independence without having to continually prove that we are STILL disabled without going over every undignified detail to numerous strangers at the whim of anyone who decrees it. If we DO need a medical please ensure it is with someone who is qualified - we surely deserve that as a very basic. I used the web site thinking it would be the easiest way of doing it. Despite submitting responses some answers have been lost and I do not have the energy to do them again. I also do not know if my questionnaire has been submitted as there is nothing to tell me that it has.</p>
ONLINE229	<p>13) whatnext08 responded:  This IS a difficult one. Whilst I do not like cheats, as I said before an awful lot of emphasis just lately has been put on disability benefit cheats which makes the public look at ALL disabled people however disabled they are as if they are cheats. I am not sure what the figures are like. I don't know any cheats but I do know people who are claiming less than they are entitled to, myself included.</p> <p>I guess one thing we could do is ask why people are cheating. Are they being greedy or are they frightened of informing you that they are no longer entitled to money because they are worried they will not have enough to live on? I don't know the answer to that one. It is a problem with every other benefit though, isn't it? If we can find the answer to why a minority (I think) of people cheat the tax payer out of money rather than report a change in any kind of circumstance that makes them no longer entitled to job seekers/tax</p>

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	<p>credits/name any other sort of allowance you like here but don't keep blaming disabled people, then you will understand how to start dealing with it.</p> <p>?) All I want to say is please remember that many disabled people are not only unable to walk or see or hear or have mental health problems (sorry if I have left anyone out) but also actually feel ill and find most, if not every, day of their lives a struggle. Personally, I take 2 lots of medication for high blood pressure, 2 for epilepsy, 2 for osteoporosis, 3 for severe pain from spinal surgery that went wrong and 3 for glaucoma, dry eye and blephritis. I have exercised all my life, kept a healthy weight, studied, worked and brought up 3 children who all went to university and despite looking after myself became disabled aged 47 years. Whatever you end up doing remember you are dealing with HUMAN BEINGS who deserve to be treated with respect, dignity and care. Most of us did not choose to end up (or start off) like this, whatever the case may be. If there are a few people who are cheating the system then find a way to deal with them without making the rest of us suffer and without making society turn against us, which is what is happening at the moment.</p> <p>?) I can only speak personally, but I fund everything from my DLA. I bought my wheelchair, all my small aids and we used it towards adaptations in the house.</p> <p>I don't quite understand the second half of the question. It makes it sound as if the payment is going to be conditional in some way "you can use it for some things but not others?"</p> <p>?) I expect there would be great implications for both disabled people and service providers. DLA is seen as giving credible access to benefits and services therefore making it easier for both the disabled person and service provider. If PIP was not seen as a passport to benefits and services in this way I expect the services and benefits would be withdrawn making them unavailable to disabled people.</p> <p>?) I have been doing this since before Christmas and I feel as if I have run out of energy and understanding. My head is just one big fog now and I started to not understand the questions properly some time ago. However, I felt I had to at least try and have a go at saying something.</p> <p>?) I think DLA has been quite useful as a means of 'proof' for getting things such as a blue badge. I believe it can be used as proof for travel permits, studying etc although I have not used it myself for these purposes.</p> <p>?) I think other people "especially parents" are far more able to answer this question than I am</p> <p>?) Provided it is agreed by all parties that the information is accurate then it could be helpful to share it with any services that require 'form filling'. I am starting to feel 'bogged down' by it all now even though I have taken days or weeks even to fill this in, but I do want to try and finish it. I suppose things that come to mind are pensions offices, social services. The main worry would be that if inaccurate information is on one form it would then be carried over to several other places.</p> <p>?) This is difficult. It is so easy to think that we always know what is right for other people but sometimes they just want to be left alone. I can remember when I wanted to be left alone. Ok, so I came out of that feeling but can it be right to compel people to conform (which is what requirement amounts to).</p> <p>Of course it could be that someone does not know which way to turn, or is so depressed by their current set of circumstances that they do actually need someone to take a leading hand. However, there always has to be a choice and you always need to know when to let go again.</p> <p>?) whatnext08 responded:</p> <p>I was in my mid 40s when I first became disabled. It was a massive shock to me. I had been active, busy, working, studying. It came as a huge shock to me. A few years later things got worse and I was a part-time wheelchair user. I knew almost nothing about these new things that were abusing my body let alone benefits, grant, aids, adaptations. Consequently, I went without a lot of things for quite a long time. I gradually got to know about things, but not before I had spent hard earned and badly needed money on things that I found out I could have got from the NHS or somewhere else. Yes, it would be very helpful to have anything and everything! Not just financial help but details of societies, clubs etc anything that offers much needed support and other people to talk to who have already started to untangle their way through the web of confusion and mess. It takes a long time to get used to disability whatever age it comes at and some people find it harder to accept than others. You have to leave everyone to get used to it at their own pace. I guess providing appropriate information in written form, so it can be put away if the person</p>

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	is not yet ready for it, to be taken out at an appropriate time is probably the best way to provide information.
ONLINE230	<p>1) The inability of the population at large to understand our needs and limitations. The unwillingness of employers to treat us fairly, let alone genuinely make allowances. The harsh climate of "me first" ambition in our world, and "Devil take the hindmost". Sort of a Darwinian atmosphere.</p> <p>2) I wish I could see the real purpose to all this change, whether that be economics or simple meanness. Or do we actually matter? We can be very "expensive". Anyway, I think that the existing differential levels should remain pretty much the same. I think you are going to spend an awful lot of tax payers' money making changes that don't save very much. I am assuming the intention is to save money?</p> <p>3) 1. Transport - I genuinely can't use public transport. So I depend on my car. My DLA enables me to keep it on the road, and therefore to avoid becoming housebound and depressed.</p> <p>2. Hospital car park fees - I attend the hospital at least once a week, sometimes more often, at £3.00 a time, or more if I have a long wait in clinic.</p> <p>3. Prescription charges - As my disease is "merely chronic" and not actually life threatening, I have to pay for all the toxic drugs I take, for which I need regular blood tests, to ensure the medication is not killing me. I also have to have eye drops, eczema creams, special toothpastes and mouth gels, etc.</p> <p>4. Shoes - As my feet are painfully damaged and deformed I can not buy shoes "off the shelf". I need special and therefore expensive wide flat shoes that will hold my orthotic supports.</p> <p>5. Adaptations to my house, bathroom, kitchen, stairs, access grab handles, etc.</p> <p>6. As my hands are weak and painfully deformed, I use all manner of gadgets and special equipment, so I can perform basic domestic chores independently.</p> <p>7. I tend to buy easily prepared foodstuffs, which is never the cheapest choice. Otherwise I depend on family to cook for me. Retaining some amount of independence is vital to me and my mental health.</p> <p>4) Those people who currently fall in the middle band will be either overpaid or deprived by the new system. How will that make them feel? Guilty, or badly treated? Disabled people do tend to be hypersensitive, because of the way society treats them. As a burden, mostly!</p> <p>5) If this exercise is designed to reduce Govt spending, then such a "personalised service" is going to prove very costly and time consuming. (However, any personalised service is only going to be as good as the people who do the testing, and I have no confidence that an administrator will understand the reality of my disease. My GP certainly doesn't!). But entitlement by "disease" won't work either, as some people are at the beginning of a recovery and some are at the beginning of a long downward path. I think incurable long term chronic diseases that force one to give up ones career and that have the effect of diminishing ones mobility should qualify automatically. eg MS, Parkinsons and Rheumatoid Arthritis.</p> <p>6) Hard to answer as I have already had to give up so many things I thought really mattered. Currently: Prepare, cook and serve healthy meals. Keep home and self clean and smart. Keep home and self warm. Spend quality time with family, friends, relatives. Get out as much as possible to stave off depressive episodes, eg shopping, the countryside, the cinema, social activities. Manage my illness and attend all appointments. Get some exercise.</p> <p>7) By making assessments based on worst days and worst symptoms (overcompensating), and allowing for this "overspend" by admitting it is really not possible to genuinely predict when it will be a good day. Often on a good day I do too much, so the following day will be dreadful. So it all balances out in the end.</p> <p>8) Any aid or adaptation that helps a person to cope should be ignored in terms of the DDA. So why not use the same criteria here? And don't make "virtual assumptions" about what someone might or might not be getting</p>

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	<p>soon.</p> <p>I think it is extremely important to remember to check all the things people can't actually do, in the middle of all this! As well as the things they can.</p> <p>9) An online form is easier if, like me, people can't write much anymore. And there have been some excellent helpful booklets to enable people to apply, like those supplied by the NRAS. They should be made available in hospitals and clinics.</p> <p>10) Evidence that the person has had to take ill-health retirement from work and therefore can't do their job any longer. Hospital records and other medical information. And don't forget they have a disability as well as abilities.</p> <p>11) A health care professional is unlikely to understand the truth and reality of Rheumatoid Arthritis. Apparently a GP only gets one new case per year, so they aren't experts either. I have little confidence of a fair assessment, as I am one of those people who "looks fine". I am not blind, and I am not missing any limbs, so what can be my problem?</p> <p>12) This is a difficult question. Currently I have DLA for life as I have a condition known to deteriorate. Maybe that should remain the case for conditions such as MS, Parkinsons, RA, AIDS, some amputations, etc. Curable and recoverable conditions should be checked frequently, say yearly for a bad back.(But then again, what about spinal degeneration?) And depression could have assessment as part of the recovery programme.</p> <p>13) What about an annual declaration, on paper, that we have to sign, like an affidavit, putting the onus on the individual, and warning of penalties. ?) A booklet appropriate to the individual problem, like the Arthritis booklet I have, from the NRAS. That has been very helpful. ?) As this debate centres on the Disabled person, then the use of the word "requirement" sounds threatening. Encouragement is more productive. I can imagine that there might be a support department set up within Job Centres where people can be invited to attend a review/support meeting. ?) Children are dependents until they are 16. They may have similar support needs, transport costs, equipment. The only real differences are: First, the parent or guardian has to be their representative and claims for the child. So the child has less of a voice in the process. Second, they need to be accompanied in travelling as they can't drive. ?) I am concerned about your definition of "greater need". We have heard a lot of that lately, as the reason for everything. In focussing on this "need" you will place vulnerable people in a "lesser need" category, take their awards away and put them on the periphery of life and work. They will be discriminated against by: The mind sets of the able bodied. The intolerance of the "presenteeism" style of management. The lack of available do-able jobs caused by increasing unemployment. Competition from younger, fitter, cheaper people. And finally, I hope you have discovered that there are many many buildings in this country that still do not satisfy the Access Requirements of the DDA! ?) I only know about the Blue Badge system. I take my award letter with me when I renew my badge. Surely that is all that is necessary? I really do not want all my personal difficulties to be electronically shared willy-nilly with anyone with access to the "system". I feel humiliated enough already with all this exposure. ?) If Disabled people are to be respected, then as each of us is different, the best thing is that each spends their money in the way they deem the most important. Very expensive items - cars, scooters, stairlifts, bath hoists, etc could be paid for from the DLA, by monthly payment/deduction. There could be a special budget pot for unusual and expensive but vital items. ?) It was vital for me to claim DLA successfully as it was the only way I could get a Blue Badge, without which my life would be very difficult and limited. ?) The greatest impact may be on those who are in their early 50s who have had to give up work because of their disability. I am assuming that many people will lose their award of the DLA to those with some mysterious "greater need". They will then be expected to go and find work to earn an income of sorts. But there will be far too much competition for places, from younger people, fitter people, able bodied people, cheaper people, graduates,</p>

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	<p>etc. So I guess that these older people will then have Depression to add to their condition. It really does not bear thinking about.</p> <p>?) Without passporting arrangements there will be more form filling, more assessments, more appeals, more distress and more unfair treatment. It is actually very stressful being Disabled in the first place, without all this change ahead of us.</p>
ONLINE231	<p>?) To get the new PIP benefit claimants will.. 'In most cases we envisage that this will involve a face-to-face meeting with an independent healthcare professional, allowing an in-depth analysis of an individual s circumstances'. As there are in excess of 2.7million people currently claiming DLA, and assuming an in depth interview takes 30 mins, it will take around 7,000 healthcare professionals a whole year to assess the current claimants. This will be lengthy and very costly exercise, which will also cause uncertainty and stress to vulnerable people.</p>
ONLINE232	<p>1) I did benefit from warmfront but only because a charity informed me of it. The passporting of other benefits need to be checked off a questionnaire to ensure that applicants are aware of other support mechanisms.</p> <p>2) I have never understood the reason to why the mobility component is not available to people who acquire a disability after 65. Are people of this age not meant to be able to go out and undertake the normal everyday activities such as shopping, or as the case will be soon, work!!!!!!What benefits will be available to support the over 65's (except euthanasia)? If we are to be expected to work beyond 65 then access to everyday life activities should also be expected.</p> <p>Again, the wealthy will not be disadvantaged to the same degree, they can afford the aids/adaptions/support whilst the middle classes and below will be at a complete disadvantage and languish in poverty.</p> <p>3) It could be combined with an adult social care assessment where used. This would give more support to the person with the disability/health condition and a more holistic approach to care needs. It will also minimise the bureaucracy and admin.</p> <p>?) There would be a duplication of information that would need to be given. This would mean that person becoming distressed when discussing their requirements on a regular unnecessary basis. It would also mean that some benefits may be missed,.</p>
ONLINE233	<p>1) Lack of information , you have to search for it all the time its just doesnt come easy ..You have to ask for help its like you dont matter if you dont .. shout up</p> <p>1) money and advice, access to events in your area ,kept informed</p> <p>2) everything apart from the large form and repeated questions</p> <p>3) been able to get out and about and keep them safe in their own environment not to cause too much distress , keeping the home warm, food , providing specialist clothes eg long button vest for larger children which are only available from specialist at high costs,been able to provide that little bit extra to support the individuals needs and funding for therapies that are not provided ,</p> <p>3) Living cost heating , extra items , the cost of disability bikes and clothing is ridiculous high, its like the companies are making money out of peoples misery and emotional distress</p> <p>4) not sure depends if you still able to fit into each component easily , more information before these changes take place.</p> <p>4) Not sure it all depends if it fare or we will have to battle to get our point across</p> <p>5) circumstances and individual as no 2 cases are the same , some dont have a definite diagnosis but still have lots of barriers ..</p> <p>6) communication and vulnerabilitys , personal care the form is far too complicated as it is and repeats its self its a big form you need , help filling it in to get your point across</p> <p>7) not having to fill the whole form in just the area you need to make change</p> <p>8) specially adapted bikes while a young child and adults can use them because the cost is far too high , which then limits people to not have then same level of life experiences and excludes them from enjoyment</p> <p>9) Not repeat questions and be able to find it simple straight to the point but we all dont know how to put the correct way to put your case forward , some people have been declined due to not putting the right words ..it has to be simple tick boxes multiple choice with a wide spectrum of answers that you can tick and not just one give a whole image</p> <p>10) the carer who looks after the individual on a day to day basis , professionals is a good idea if you see them regular</p> <p>11) the only thing i can see is if you are seen by some one for one day it doesnt really give the bigger picture you could be having a good day in which would not show a true light of</p>

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	<p>the whole day to day life. everyone should be seen by a professional on a regular basis but with the huge case loads already upon them would this not cause longer wait times to see a professional</p> <p>12) this is a definite as some people are not going to change but you still have to fill in a long form , doctors letter or key workers involved with the individual</p> <p>13) alot of people spoil it for the honest .. the present forms are out dated it like if you get higher rate with a child or adult who isnt going to change still have to refill the form in every 3 years and the ones on lower and middle get 10years to renew it seems crazy. you should be able to renew by phone like tax credits yearly by the carer or individual, save on paper work and if they dont its stopped.or maybe a letter from the doctor as of proof nothing as changed.</p> <p>14) been assigned to an individual person whole deals with your claim and guides to other services , instead of having to spend searching rather than enjoying life to the best you can</p> <p>15) easy access to advice key worker to your case and no long winded forms or complication the vulnerable will find it to confusing adding more stress and upset</p> <p>16) charity or struggle to get help ,the payment it self is for the extra money it costs you to survive by using that to fund aids at the current cost it would mean waiting months upon months to afford it ! alot of other countrys provide aids as part of the nhs you go to the doctor for a pescription to provide with such things</p> <p>17) I dont think age is an issue as most children if they have difficulties are still children and adults for that matter , if some one needs help its based on the individual not age and if a child reaches so called adult age they should not be classed as an adult if they still have the mind of a child , it can be very upsetting ..</p>
ONLINE234	<p>1) I speak for myself - I suffer chronic illness - the barrier to a full life is my health. No matter what assistance I receive, I will not be able to lead a full life. Financial assistance means I can have electrical items to assist and live in a quiet environment, but no amount of money could make me participate further in society because my health dramatically restricts my energy, therefore I can only do "small bites" of participation in society.</p> <p>2) Awards are currently given for 1 year, 2 years 5 years etc or indefinite. Whilst there is a need to re-assess people, if a person's condition is likely to be lifelong, there would be little point in putting that person through constant re-assessment. There should be 10 year re-assessment at a minimum for such people. My life depends on DLA - my home - mortgage and if the benefit was under constant review, I would not know if I was likely to become homeless in a year or two if there were constant reviews and I was at risk of losing the benefit or having to constantly appeal. Also the evidence that can be given by a person's GP, consultant etc should be held in high regard as they are likely to know the person better than a quick ATOS Doctor's report. If not we will end up with the ridiculous ESA system.</p>
ONLINE235	<p>1) Not all disabilities are the same but unfortunately society gets to feel that they are and just makes the basic of changes to incorporate everybody but in doing so make the person feel even more disabled. When putting in dropped kerbs they are not always opposite one another or sometimes there is one on one side and not on the other so the disabled person who is in a wheelchair or mobility scooter may then have to drive in the road to find another dropped kerb to get up on ther pavement.</p> <p>One last point not all disabled people are in wheelchairs and may have mobility problems and it would be of help to have chairs/seats nearby their route to have a rest.</p> <p>7) I am not sure about that and it worries me as I have multiple sclerosis and after coming out of bad relapse a doctor called on me for an assessment. Whilst in the relapse I could just about walk and would open the door and it was an effort to get to my car which was just in front of my front door. On coming out of my relapse it was like a miracle and I felt able to instantaneously do everything that I could do before. I was therefore turned down for DLA and had to write to my MP to get it reinstated. My point is one never knows with MS how long the relapse is going to last and when the relapses stop and start again</p>
ONLINE236	<p>1) Low income is a major barrier to being integrated into society. Lack of physical support is often an issue as LA budgets have been reduced and the support available via the independent sector is poorly paid due to LA payments and grants being reduced. This results in tender decisions being made purely on cost and can therefore result in staff being poorly trained and poorly paid, therefore de-professionalising the social care sector. Employers are less keen to offer employment to those with a disability as they are afraid of the potential for higher absence costs. This is often not borne out in practice but employers</p>

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	<p>are sometimes not willing to take the risk. Their decision will not mention disability but will say a better person got the job! The supported employment service needs to be better resourced to address this and more information for employers to encourage them to offer employment would be useful with a potential benefit such as a grant or reduction in NI payment for that individual may assist.</p>
ONLINE237	<ol style="list-style-type: none"> <li>1) I am a full-time carer for my husband, he has post-stroke disabilities which include severe restrictions in mobility, visual impairments, epilepsy and cognitive deficits including severe memory difficulties. Any one of these would make be a barrier but together they mean we are both very limited in how we can participate in society.</li> <li>2) The mobility component should still be available for those in residential care otherwise their movements will be severely restricted and they will become even more dependent and institutionalised</li> <li>3) Transport care, assistance with personal care, wheelchairs, hoists etc.; incontinence pads; extra washing and cleaning (we sometimes have 7 loads a day!) extra heating costs - immobility means people feel the cold more.</li> <li>4) Some people who receive the care component now may get less as it is currently a three tier benefit</li> <li>5) Every one should be looked at individually and have their individual needs assessed as most conditions have a very wide range of symptoms and effects.</li> <li>6) Everyone needs the basics - food, shelter, warmth and hygiene</li> <li>7) The assessment should allow and encourage people to describe their situation on their worst days and be trusted with their answers - disabled people are not dishonest people they just need help to get on with their lives.</li> <li>8) Absolutely and they should be helped to get any adaption or aid that will improve their quality of life.</li> <li>9) There could be people who were able to help those in difficulty to fill out the forms</li> <li>10) Medical practitioners</li> <li>11) I think this is a good idea but there should be provision for a second opinion if their assessment conflicted with the person's medical assessment by their own GP for instance</li> <li>12) The disability - sometimes a condition may improve but in other cases the prognosis is one of deterioration so some cases may need reassessing every 12 months, but others may not change over 36 months. Medical practitioners are best able to make these kind of assessments</li> </ol>
ONLINE238	<ol style="list-style-type: none"> <li>1) Society's attitude towards anyone who does not conform to "the norm". My son has Down's Syndrome. He is 21. Bright, full of energy and a hard worker. But he is seen as a Down's person rather than a wonderful human being who just happens to have Down's. He will fulfill his potential given the chance unlike a lot of "normal" 21 year olds who think drugs, crime &amp; living off the state is the way life should be.</li> <li>2) No! The form is far too lengthy &amp; puts a lot of people off bothering, particularly if there is any learning difficulty. The form repeats itself over &amp; over. It is so easy to abuse the benefit too. Anyone can put anything on the form with no rigorous checking done. People in need don't get it &amp; people with no difficulties in reality do.</li> <li>3) I can only speak from having a son with learning disability. It costs a lot more to entertain him as he cannot always entertain himself so we go out more often. He also has to be accompanied when he goes out so an outing costs twice over. People with Downs' very often have shorter bodies than average. I have to pay to have clothes altered for him. Sometimes people with disabilities need adaptations at holiday camps for example. Specialist sites cost a fortune.</li> <li>4) It will make no difference at all. People with disabilities need to be assessed regarding their day to day life. If this costs money so be it. A nation is only as good as how it looks after its most vulnerable. This will still be abused to hell.</li> <li>5) Yes of course. It is an insult when someone who is quadraplegic has to jump through the same hoops to get an award as someone with excema.</li> <li>6) Getting in &amp; out of bed, washing, dressing, toileting &amp; eating should be a right not an option. Plenty of people are unable to function at the most basic level in this country due to money not being spent. Everyone is entitled to persue going out/entertainment/hobbies with help if required at least twice a week.</li> <li>7) Face to face assessment and robust checking systems.</li> <li>8) No. The person's ability/disability should be assessed as is. One person may have afforded to get an aid while the next person might not be able to.</li> </ol>

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	<p>9) If a form is to be retained then it needs to be simple and too the point. Get the Plain English people involved. No more than 10-12 pages.</p> <p>10) Depends on the disability. I had to get a GPs letter when my son hadn't seen his GP in years as he is a healthy young man. Ask the applicant which professional sees them the most in matters concerning their disability. Could be a Community Nurse, District Nurse etc etc. Doctors and hospital staff aren't always the best to contact as they don't see the person at home.</p> <p>11) Good idea. They will be able to inform the Dept about the day to day life of the person. Maybe better than the applicant again particularly if there is learning difficulty. Sometimes the problems experienced each day are glossed over by the applicant as they have become "normal" over the weeks/months/years. I completed a form for a lady once and asked her if she could get up &amp; down the stairs unaided. She said yes. It was only after talking further it was revealed she could only do it on her bottom &amp; it sometimes took 30 mins each "way".</p> <p>12) Reviews need to more parallel. From when my son was 5/6 he had severe behavior problems and had to go residential school. He had a 4 year DLA award. His friend of the same age with Downs', with no behaviour problems, better ability and far easier to care for (his mother's words) got a life award. It's a joke.</p> <p>13) You would need to see the professional again for up to date situation. Otherwise you won't.</p> <p>?) I don't think it gives any access to anything. List things that maybe available in addition.</p> <p>?) If PIP in payment there shouldn't be any need for duplicate medical certificates to pay Incap/ESAS. This could be looked at electronically. I think staff dealing with PIP should go to Disability Groups/Special Schools to see what day to day life is like.</p> <p>?) It has NEVER been stressed enough that DLA could be claimed when the difficulties arise NOT when a diagnosis is made. Autism is the classic example. Parent realises problems when child is 2/3. Gets diagnosis at 4/5. Claims DLA. No backdating even though the child will always have had Autism.</p> <p>?) PIP is a ridiculous name. People will get the pip alright!</p> <p>?) See Question 14. It's a vast problem but it must be addressed as much as possible. Health visitors, GPs, specialists etc should have the knowledge to tell parents that they can put a claim in for PIP even though the problems aren't diagnosed. After all some people never get a diagnosis. Get the benefit out there where parents are. Nurseries, play groups etc.</p> <p>?) That's obvious!!</p>
ONLINE239	<p>1) These are many and varied. They range from higher than average living costs (for example the need for additional heating, specific diets, adaptations to accommodation, additional transport costs, payments to carers/cleaners/gardeners) to difficulty in gaining and keeping a job because of employers reluctance to employ staff with disabilities and possible associated ill health and sickness absence. Accessibility of public facilities is still a big problem, and provision of holiday accommodation which is suitable for people with disabilities is still relatively limited.</p> <p>3) the need for additional heating, specific diets, adaptations to accommodation, additional transport costs, payments to carers/cleaners/gardeners</p> <p>5) There will be some conditions where assessments would always result in eligibility and others where needs are likely to be more variable. For those conditions where the probability of eligibility approaches 100% it would be a waste of resources to carry out assessments for all those with the condition. It may be appropriate to review the conditions for which automatic entitlement applies.</p> <p>There may be an argument for a minimum entitlement which comes automatically and an element which depends on an assessment of the needs of the individual.</p> <p>7) Include evidence from a range of sources, such as medical practitioners, carers, social workers etc. Take into account the effect of interview on individuals temporary capacity. Use extended assessment approaches.</p> <p>8) The assessment should only take into account aids and adaptation which can be used. It is quite possible that the individual may not actually be able to use aids that the assessor thinks they should use. However, evidence of an attempt to use possible aids could be taken into account in further reviews</p> <p>16) Yes</p>

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ONLINE240	<p>1) The main difficulty preventing disabled people from leading independent lives is affording transport that they are able to use. Access to public transport for the physically disabled is still a barrier. For many people who are severely disabled using a car is the only way that they can practically do shopping, visit relatives and friends, go to work and access entertainment outside of their homes. Cars usually need adaptations that cost extra money. I have been disabled from polio since childhood and Without being able to afford a car I would not have been able to go to university, keep in full time work and now that I am retired do volunteering work. My life would have been infinitely less full and I would have been unable to support myself financially and lead an active life.</p> <p>2) The additional costs for people with disabilities do not go away because they are above a certain income threshold. It would be unfair to means test the benefit. The passported benefits should also be retained, particularly access to a blue badge to aid parking and the disabled taxation class and congestion charge exemption. Disabled people frequently need cars with automatic transmissions and this usually puts them into higher emission bands.</p> <p>3) Needing to run a car rather than being able to walk, cycle or use public transport. Adaptions to their homes. Although the local authorities should provide help with this it is becoming increasingly difficult to get them because of funding cuts. Wheelchairs, callipers, crutches and special shoes and boots. Although the NHS has traditionally provided these things it is becoming increasingly difficult to get them as services and budgets are cut.</p> <p>5) Where a person has a lifelong disability that will only get worse e.g. paralysis from a birth defect or as a result of a disease like polio it seems like a complete waste of resources to reassess them on a regular basis. Someone who has to use a wheelchair or callipers and crutches to get about is almost always going to incur additional costs for them to do normal things e.g. going to work, shopping, visiting relatives and friends and social activities.</p> <p>6) Working where possible allowing them to support themselves, shopping, visiting family and friends, social activities in that order.</p> <p>7) Making sure that the organisations assessing the disabled people take account of the times when their condition affects them the most and basing their assessment on that not on people's best days.</p> <p>8) Wheelchairs, callipers, crutches, special boots and shoes and artificial limbs. People should be assessed based on the adaptations that they currently use. If adaptations are available that could help them they should be referred for advice. It would be unfair to assess them based on adaptations that may not work for them.</p> <p>10) Health professionals who have known the person for some time. Carers who live with the person or visit the person regularly.</p> <p>11) Any assessment where people fear that they may lose a benefit will be stressful. There will be costs and difficulties associated with having regular assessments. e.g. costs of the travel, having to take time off work. If the disability is related to a person's mental health the additional stress of these assessments may be detrimental to their health.</p> <p>12) If the person has a lifelong disability either from birth or from a disease such as polio and the condition will not improve it seems to be a complete waste of money and resources to reassess them frequently.</p>
ONLINE241	<p>1) Generally it is lack of understanding/consideration of others that limits disabled individuals. Past experience, leading to lowered self esteem/self confidence is also an issue, as is lack of experiences. Need for individuals with long term disabilities to have received correct care and intervention from early on, as well as correct educational support to maximise their potential for success in later life.</p> <p>2) Should not be means tested</p> <p>3) I am dealing with a disabled child. The intensive therapy he requires is difficult to access through NHS and indeed even through his specialist schooling, and thus private costs have been incurred. First hand experiences are key to his understanding of the world, so much has been spent on providing these. Simply accessing his specialist schooling has meant that other siblings have had to attend out of school facilities to facilitate getting disabled child to and from school, and thus further costs on the family due to his disability have been incurred. Frequently the impact and costs on siblings and family as a whole through having a disabled child are overlooked/ not considered</p> <p>4) It would indeed make system easier to administer, but will it offer same amount of</p>

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	<p>financial support, or is it simply a means of cutting cost, eventhough there is need?</p> <p>5) It is obvious from knowledge and experience that certain disabilities clearly are likely to incur an increased cost and impact, and thus should have an automatic entitlement, but perhaps the matter of higher or lower band should be determined on an individual need basis</p> <p>6) Difficult due to subtleties of some disabilities. Obvious physical disability is easy to spot, but for example, impact of language difficulties and associated social difficulties are harder to judge on a "one off" assessment, where the impact of lack of comprehension and ability to function to "the norm" socially has a huge impact. Self care and safety has to be a factor, but so too does ability to understand world around and ability to communicate effectively - to make self understood and to understand.</p> <p>7) Benefit has to be limited to a 2/3 year period for all, and renewal process has to be universal. Reliance on individual to report change in need within 2/3 year period also must be applied</p> <p>8) Physical aids e.g. wheelchairs, should be considered where they are in place. Common sense needs to prevail in such instances, e.g. wheelchairs don't replace legs, and mobility issues may be partly overcome, but still there!</p> <p>9) Personally I found information on the benefit scarce, and took me years to discover my son may be eligible for it. Found forms complex, and difficult to fully explain impact of his disability within constraints of question. I realise there has to be a standardised form, it is difficult to design a "one fits all"! Also took me over a year from receiving DLA for my son to realise I was eligible for Carers Allowance. Lack of information is an issue/concern.</p> <p>10) In case of child, parent knows best, backed up with medical information from professionals and schools who deal with children. Medical professionals obviously need to be consulted for adults. Are you looking at professionals with specialisms in areas of disabilities, or just a medical assessor for assessment of abilities? e.g. My son's paediatrician treats my son for allergies, and is knowledgeable on his disability, but leaves that side of things to other professionals as he feels that it is not his specialist field.</p> <p>11) Face to face is fine, but as a parent who has spent hours and days in hospitals and clinics in relation to my child's needs I feel it may be a duplication of effort when reports from professionals who have been dealing with him for years are available to DWP assessor. Doesn't this simply increase the cost of administering the benefit? I see the need in adults who are perhaps not followed so closely in some circumstances.</p> <p>12) If criteria for receipt of benefit is long term need, then surely a 3/5 year review period is acceptable, or perhaps reviewing medical reports in interim.</p> <p>13) There has to be a clearly explained penalty for not informing on change in circumstances. Is it not possible to have direct link to patient's GP, who would be made aware of benefit claim, and could thus also inform of a change?</p> <p>?) Common sense and decreased bureaucracy must prevail to make system more equitable and efficient. Hope aim of change is this and not simply cost-cutting!</p> <p>?) Fact that generally they are well monitored already, and usually "within the system" so information can be accessed easily on them from professionals. Consideration of impact with regard to cost on other members of family of having a disabled child to cater for.</p> <p>?) Having a disabled individual and meeting all their needs tends to be a battle and rather exhausting in itself, without having to source further help that does not follow from P.I.P.. Please simplify the system, taking into consideration the demands carers already have on them!</p> <p>?) Helpline may be useful, but how manageable/cost effective? Website with e-mail link might be more effective</p> <p>?) I think clear definition of purpose of the benefit and listed criteria/definition in relation to disability.</p> <p>?) Impact of disability on individual's life and ability to function in society has to be at forefront of policy. Thus increasing disabled person's ability long term to contribute economically to society</p> <p>?) My experience is only with disabled child, so automatic link to carers allowance and child tax credit would be useful. Link between DWP and GP is surely acceptable, and perhaps has to be an agreed criteria in order to access P.I.P. benefit, thus allowing DWP to have updated information on individuals, without more paperwork, particularly with technology available</p> <p>?) Personally, I stumbled across this benefit. No-one pointed it out to me, and even once in receipt of it for my son I was not aware of how it linked to other benefits and supports. Only</p>

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	<p>since joining and being involved in various support groups have I become more aware of links and "passporting". More information definitely needed and better communication ?) The costs in relation to my son are constant and consistent. May be useful to have option to meet a "one off cost"</p>
ONLINE242	<p>1) The need to use their own personal transport.</p>
ONLINE243	<p>3) As a BSL user I cannot follow anyone without sign language (it is impossible for me to lipread even though I spent 15 years in an oral only school where there is no signing allowed). To communicate I rely on others who can use sign language and unfortunately they have to make a living and charges between £25 to £45 per hour with a two hours to 3 hours minimum call out charge which is very expensive indeed. So I use a video interpreting service which charges about £2 per minute which is expensive but does not carry any minimum call out charges so I can use it for short meetings or discussions with hearing visitors who cannot sign.</p>
ONLINE244	<p>1) Practical physical problems of accessing buildings and locations and transport in a wheelchair. Also the physiological problems where disabled people are generally thought of as stupid or incapable or not interested even in doing things people take for granted.</p> <p>2) It should remain non means tested and paid to the disabled person.</p> <p>3) Paying for a large enough car to carry an electric wheelchair, a larger car that costs more to run than the average family car. Also the cost of care, the carer is unable to work when the disabled person needs to be taken for hospital appointments regularly and needs constant care, help with dressing, toileting, feeding etc. The disabled person needs equipment that can't always be provided by social services such as electric wheelchairs and their maintenance (only manual chair supplied by SS). Also a holiday cost much more for a disabled person, disabled rooms cost extra and the types of holidays are limited.</p> <p>5) Having to live life in a wheelchair automatically exposes the disabled person to extra costs so should be automatically entitled.</p> <p>6) Care is very important, disabled should be able to afford the extra help they need to live independent lives. Transport is also very important for independence but is very expensive to purchase in the case of wheelchairs and to convert and maintain in the case of cars.</p> <p>7) This, in my opinion, can only be tackled by asking questions on the amount of help the disabled person has needed in the previous 12mths. Or make it clear the questions are to be answered based on the worst of times.</p> <p>8) Running costs of aid and adaptations should be considered. For example, running a larger wheelchair adapted car, machinery such as feeding machines, insurance and maintenance for electric wheelchairs, heating costs associated with being at home through cold winters.</p> <p>9) Filling in the form is very difficult because most carers or disabled do not think in hours of help per day. It is difficult to really put down how long it takes to dress someone as this may vary day to day or on the season, toilet visits are not logged, bathing done based on need which may vary daily.</p> <p>Information can only improve by making sure social workers, physios and OTs are clear on who is eligible.</p> <p>10) Often a disabled person's local doctor has little to do. Most often it is the community physiotherapist or Occupational Therapist or hospital specialist who has more input and understanding of the condition. Thus supporting evidence should be from a care professional who has most involvement.</p> <p>11) Face to face is often better unless the disabled person has difficulties with communications or behavioural problems associated with shyness. Often a short visit by a care professional is not sufficient to get the whole picture, reports from people involved on a daily or regular basis should be just as important.</p> <p>12) I think the timing of reviews should vary depending on the person and the condition. With some conditions the disability is stable, unlikely to improve or get any worse, so reviews are needed less frequently. Doctors or health professionals can advise on this.</p> <p>?) Currently more than half of DLA pays for a large enough car to carry the wheelchair. I think the key here is flexibility, the disabled person will use DLA to improve living as best as possible. Perhaps one off higher payments could help with a particular aid?</p> <p>?) we once had someone help us understand how to answer the questions and helped us fill in the form, this was extremely useful. Often once you have been helped you don't need this help again next time.</p>

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	?) what other services? Apart from carers allowance it seems a disabled family are not entitled to any other help, even winter fuel payments or reduced coarse fees if someone in the family has to work!
ONLINE245	<p>1) Lack of educational opportunity, need for adadpted housing AND built environment, need for Personal Assistance (with things like eating, toilet etc) Need for mobility equipment and adapted vehicle, lack of awareness in general population, need for increased items of clothing (dribbling, incontinence, messy eating etc) and much more washing.....</p> <p>2) Should be kept separate care/personal and mobility. Should be at least 3 rates of personal due to vastly different needs that cannot be met by 2 simple rates.</p> <p>3) Larger houses, more washing, specialist food, more clothes, bedclothes, equipment (this is a huge area - mealtime bobs alone for my son cost about £200 every year or so), large vehicles which are very fuel-hungry, more expensive holidays (not able to take advantage of last minute deals) and travel</p> <p>4) 2 rates may be OK for mobility but much too simplistic for peronal and care, if it is truly to be as flexible and person centred as the govt document suggests. Trying to fit the vast range of disability needs into one of two categories will lead to many, many people not getting the level of support they need - or actually in some cases, getting too much.</p> <p>5) Hard to say - VERY much depends on the caliber of the vast army of assessors who will be needed to actually carry out the assessments; and my fear is that this is a nightmare waiting to happen becuae the training implications are HUGE if they are do do the job correctly. For example my son (12 years) has athetoid cerebral palsy and one part of that is no speech at all. So he uses alternative methods. Sounds simple but is in fact vastly complex and has many many ramifications for his social, educational and emotional development. Someone assessing him would need to understand a fair chunk of this otherwise they might look at the fact that he has a communication aid and think "sorted"...when in fact the aid is just a tiny part of the picture.</p> <p>6) Being able to be as involved with society as the person desires; having the infrastructure and support to take part, to get around, to communicate and make choices about their own life</p> <p>7) By having enough (ie lots) of highly trained assessors who can actually do the assessing. But also by being realstic about what it means ot have a fluctuating condition - may well not mean a person is right as rain one day and totally incapacitated the next - benefits must be averaged out cos even on a "good" day a person is affected in many ways by their not so good days.</p> <p>8) Yes, but with some VERY BIG provisos; the person should have the correct aids, the correct support/training to use them, and how they were funded (and how their replacement will be funded)MUST be taken into account.</p> <p>Also the fact that a person with a significant disability may have a range of aids and equipment - but may often still needs full time support, more clothing, a bigger adapted gas-guzzling car etc etc etc must be recognised. So their need for more financial support has not really been lessened.</p> <p>10) Very difficult to say who is best placed to provide a clear assessment of ability - ironically it is often NOT a medic, esp. with many physical disabilities where the person is not actually ill and rarely sees the GP. So you may need a speech therapist, a social worker, an occupational therapist, a physio, friends, family, school staff for a child, and the person themselves to get a clear accurate picture.</p> <p>11) As I said in Q10 - a healthcare professional is often NOT best placed to assess in cases of physical disability. Face to face discussion must allow for advocacy, interpreter, an understanding on the part of the assessor about how the person communicates if they have poor or no speech. The assessor must be able to speak to people with varying levels of cognitive impairment without patronsiing or making assumptions. And above all they need to be highly skilled and knowledgeable about how a person may be affected by their disability.</p> <p>- Many people would actually find a face to face quite intimidating and there is a huge issue with peoples pride and not wishing to seem as if they need help or can't cope; a good assessor must be able to see past this</p> <p>13) By making it very easy to both reduce the level of PIP - AND to re-instate it if needs increase again. How Carers Allowance works now it a good example of how to make it cumbersome and lengthy to report periods of non-eligibility and then to re-instate it again!</p> <p>?) Families with disabled children are statistically much more likely to be living in poverty</p>

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	<p>and in unsuitable housing. They are also more likely to separate and to have only one working parent.</p> <p>Costs can be huge in terms of attending appointments, getting therapies, clothing, washing etc etc.</p> <p>For example my son's school have just introduced a new uniform. He needs 2 clean jumpers a day due to dribbling etc - so I have to pay for a minimum of 8 new jumpers (in order to allow for washing, spares etc) These cost around £13 each so I have to find a minimum of £104 just for jumpers when my other son has managed on 2....</p> <p>?) Where children are concerned a lot of families go to charities for equipment like wheelchairs, beds, seating, walkers, communication aids etc. This option is simply not open to adults as there are very few charities which fund adult equipemnt. There are many items which are actually the responsibility of health and/or the local authority - but getting these is a very different matter. So for some items an elemnt within the PIP would be very useful indeed. But it has to be enough money to meet equipment need and it must not be at the expense of care or mobility. it should be an "also" not an "instead"</p>
ONLINE246	<p>1) Barriers to society are not only physical but also attitudinal. Information is only provided in accessible formats on request, not as standard. Not having full access to high quality information puts up barriers to every other aspect of life. Additionally funding for social care is woefully inadequate resulting in underinvestment in care services and rationing of assistance from social services. More and more people are being refused financial assistance for care services or are having packages cut with charges being increased at the same time. Packages are more and more likeley to consist of the bare minimum feeding, watering, toileting and dressing services - leaving people ever more socially isolated and less likely to be able to participate in any meaningful way in the community / work market. Additionally there has been ever more negative press concerning benefit fraud (particularly DLA for some reason) with innocent people labelled as scroungers even though they are just claiming what is rightfully theirs to claim - this has led to disabled people being viewed in a poor light which in turn has lead to a confidence crisis not only by the disabled person themseves, but also by potential employers or even potential partners. Unfortunately with the sweeping cuts that this government is bringing in this just adds to the devaluing of disabled people.</p> <p>Financially disabled people are one of the poorest sectors of society not only because we are devalued but also because of the additional expenses we have when it comes to extortionatley priced specialist equipment and the fact that many of us have to essentially pay to be able to get up, get washed etc (in terms of care charges) whereas non disabled people do this by themselves (for free!)</p> <p>2) The rate paid proportional to the cost of living - cutting the payments when things are already tight is going to seriously affect peoples' health / ability to live within their means. The recognition that a person's mental health issues can be as disabling as any physical impairment.</p> <p>That people with fluctuating conditions are entitled even though they sometimes appear well / less disabled.</p> <p>That the individual is the expert on their own lives - and although medical checks / reports from professinals can be helpful they can only give a shapshot of the person on that particular day/time</p> <p>3) disability specific costs: self funded care, "contribution" to care provided by social services, disability equipment not provided by statutory authorities.</p> <p>incidental cost: higher fuel bills due to the need to keep warm/cool and/or the need to charge up equipment such as wheelchairs, hoists, envirnmental controls etc. The addtional cost of having an extra member of the household if someone has a PA for large amounts of time. Higher petrol costs for people with large wheelchair access vehicles of who can't access free travel with the freedom pass</p> <p>4) There will be big gaps between the amount of money recieved by those who only just miss out on the higher rate. With the 3 rates for care at the moment, it recognises that cost is proportional to assistance needed and while there is not a "pound per point" type system that probably would be fairer than the 3 tier system, it is still more fair that just having two levels.</p> <p>Personally I don't see how reducing it to 2 levels will have any benefit in terms of administration - you just have to administer the payment according to the decision - it doesn't matter that there will only be two levels.</p> <p>In terms of appeals - without a middle rate you are bound to have more people appealing if</p>

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	<p>they are significantly more disabled than others getting the lower rate, yet not disabled enough to automatically reach middle rate. I think that this, as well as the tightening of social services eligibility criteria, will lead to people not being able to get/afford the increased cost of care - leading to an increased need for care/ hospitalisation.</p> <p>5) I think that, given the wide variety of effects, even within one specific condition / impairment so there should not be automatic exemption for the vast majority of medical conditions - however if someone has suddenly become a tetraplegic, for example, it is quite cut and dry and would save admin time for people in such groups. Also, if someone has a progressive medical condition, such as muscular dystrophy, and it has already progressed to such a stage to trigger the higher rate it is pointless to keep reviewing, as the conditions are not likely to improve (unless there have been significant medical improvements)</p> <p>6) I think that Joseph Rowntree did a quality of life study in which they concluded that being able to have one holiday a year. I think that currently the government and especially local authorities focus too much on "survival" (feeding, washing, dressing, toileting etc) and the real quality of life issues (participating in the community, hobbies, education, work, holiday and having a bit of autonomy) have gone by the wayside. People are not unable to "live full and active lives" because they are disabled, but because society still isn't set up to provide the access, assistance and finances to allow disabled people to live full and active lives</p> <p>7) Consult this group of people specifically about this question as they will be the experts on the difficulties they have and possible solutions</p> <p>8) Take into account aids / adaptations that the person already has, not ones that could possibly be of some use under certain circumstances if the person got them some time in the future!</p> <p>Aids/ adaptations are rationed by social services and often even if you research something that could be of use they won't provide it, or will provide something cheaper. You cannot, therefore, count on someone being able to get the aid/adaptation that could conceivably be of use and by assuming that the difficulties will be overcome with an aid/adaptation reduces the choice of someone to have that need met in another way. As choice and control are the current buzzwords making a decision about funding based on something that the person might or might not be able to access seems counterproductive, especially if the funding from the DLA is their only way they can afford the price of equipment in the first place</p> <p>9) Provide good quality advocacy/ welfare rights services to assist people to fill in the form would help. Also ensuring that the form / information is written in easily accessible, unambiguous language and it is available in lots of different formats. There should also be plenty of space for people to elaborate if they want to, but still be a simple form that will give most of the information if they don't want to write much. You could offer people the choice of filling the form in ways other than written - for example, drawing, pictures, audio, video</p> <p>10) Things like LA care/ needs assessments, Personal Budget support plans, OT assessments etc are often more helpful than a report written by a doctor/ consultant, which doesn't really tackle the practical difficulties that the particular person has. When I visit my GP we talk about medication, blood pressure etc - everything except how my impairment affects the practical aspects of how I live my life!! Social services are moving more and more to self assessment (or assisted self assessment) as it is recognised that a 30min assessment by a "professional" can't identify all the issues that a person experiences in a range of different practical circumstances. DLA has always been about the effects a person's impairment has, rather than the name of the impairment, so medical reports probably don't help much!</p> <p>11) As above - Social services are moving more and more to self assessment (or assisted self assessment) as it is recognised that a 30min assessment by a "professional" can't identify all the issues that a person experiences in a range of different practical circumstances. DLA has always been about the effects a person's impairment has, rather than the name of the impairment, so medical reports probably don't help much!</p> <p>I think that if the person has a reasonably up-to-date assessment from the local authority, a Personal Budget / Direct Payment support plan in place / a OT assessment etc, this would be more likely to cover the type of practical things than a face-to-face appointment with a healthcare professional who would not be a specialist in the "condition" that you have anyway! If it is clear that one agency is having a financial input into a person's care needs</p>

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	<p>then there should be less doubt that these needs are not true (I am sure that, where people have defrauded the DWP via DLA they haven't tried the same with the Social Services as they wouldn't actually need the care they would provide!</p> <p>12) First and foremost you have to understand the the word "review" strikes fear into people claiming DLA. This is money that makes a real difference and the treat of losing it is terrifying. Some people don't even ask for their claim to be looked at because of increase needs for fear of losing what they already have. AND there have been so many people who have lost out because of the works of fiction from the ATOS healthcare assessors - so reviews are a real cause of stress and anxiety.</p> <p>Saying that I understand that they are something necessary so if the person asks to be reviewed then they should be, even if the official review isn't due (but if they only want one component to be reviewed they shouldn't be at fear that they will lose the other just by asking to review on part).</p> <p>New claimants could be reviewed more often (I know I was at first) but then after someone has shown that their need is stable then they should be reviewed infrequently. If someone has a condition that is incurable / can't be improved with interventions then there should just be the "indefinite" category.</p> <p>With regards to the people that phone in to the informant line, I think that there needs to be careful checking as a lot of people phone in maliciously and thus causes great distress. If a person is investigated and exonerated then other reports should be treated with scepticism and not generate a review.</p> <p>As above, if the person is receiving an input from Social Services then this really needs to be considered whether a DLA review is necessary (although you have to also recognise that, as eligibility gets tighter, people might lose the right to help from the council but still have the same level of need.</p> <p>13) Not make people fear reporting changes! A change in mobility needs shouldn't threaten a person's eligibility to the same rate that they currently get for care.</p> <p>If a person's needs are seen to have decreased there shouldn't be a sudden stopping of the money - it should be tapered off and advice / information given as to how to cope with the decrease in "income". If the decrease affects other funding for care then this should be carefully considered - currently you only get independent living fund money to part fund someone's care package if you get higher rate DLA - a cut in DLA means loss of ILF funding and immediate problems with the care provided by the council!</p> <p>?) Advice and support should be universally offered and encouraged, however welfare rights services are already overstretched. Making it a requirement for all would delay applications / appeals, whereas encouraging people to do so, and actually investing in organisations (such as user-led organisations of disabled people) to provide this support would help.</p> <p>There is also currently real negative press with regards to "benefit scroungers" so all claimants are being tarred with the same brush even if they are legitimately entitled rather than defrauding the system. This is not only through stories in the paper and "saints/ scroungers" programs on the TV but also in the Government's clear "attack" on disabled people through policy (reducing benefits, increasing assessment, withdrawal of funding to council where social services are the main ones that take the hits with care packages being cut and people charged more, and dissolution of the Independent Living Funds.</p> <p>More positivity about people's right to claim, that disabled people are not just a drain on the system and can be economically productive with the right support etc, would stop all the scapegoating! Investing in disabled people's organisations to provide this support/ advice would go further to promote disabled people as being active.</p> <p>?) eligibility, how to apply, whether other benefits would be negatively/positively affected, how to get help completing the form, what the money could be used for, what the individual's responsibilities are, how to appeal (simple and with a quick outcome). And for people who are moving onto it from the DLA - what the differences are - what negatives and what positives are there.</p> <p>?) it is even more important for children to be able to have as many opportunities as their peers regardless of their impairment. Often children are "made to sit on the sideline" as it is more difficult to ensure they can participate and this is not good for their self esteem.</p> <p>Additionally, for many parents they believe that the child would have been more independent if they were not disabled compared with a non disabled child of the same age and this impact significantly on the family as a whole. Although it may be that some aspects of caring for the child are the same e.g. the mobility needs of a very young child -</p>

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	<p>this parental role is expected to get less over time</p> <p>?) it would mean more stress, hassle and more fighting for something that we are entitled to. This would lead to less people receiving their full entitlement just to avoid the stress of applying.</p> <p>?) joint-up working in terms of: income support (disability premiums, housing allowance (extra room for carers), council tax (reduction for accessible properties), tax credits (disabled person's tax credits), Access to work payments).</p> <p>joint up with social services care needs assessments, OT assessments, respite providers, hospital discharge, reablement/rehabilitation services, district nursing/community psychiatric nursing and wheelchair services.</p> <p>Having a "Can we share this information?" question after each section would allow the person maximum control of what they do / don't want to share.</p> <p>?) reducing the amount of money paid will have drastic effects to people who are already classed as some of the poorest in society.</p> <p>?) small pieces of equipment are often paid for using people's disability benefits. If people are lucky enough to be eligible for social services funding people can apply for a DFG or use a Personal Budget to pay for such equipment. It is worth pointing out that, even though there are statutory services that can provide aids/adaptations, or funding for such, due to the strict eligibility criteria most people are turned down. Charities have been a good source of funding too but this is drying up too. People are having to rely more and more on benefit.</p> <p>?) The proposals about assessments will undoubtedly be unfair for people with fluctuating / mental health conditions. I think the invasive forms also don't cater for certain religions / ethnic groups for whom sharing personal information or submitting to non essential medical examination causes conflict.</p> <p>?) with disabled people having to fill in invasive form after invasive form (often with equally invasive review, assessments and interviews) it is essential that this burden isn't increased. Currently certain levels of DLA do passport to other benefits , components , services etc. Additionally, the government has recognised that large numbers of people don't claim the benefits that they are entitled to , so automatic passporting goes some way to ensure that when people have claimed DLA, all other possible components are triggered without having to go through another form or assessment.</p>
ONLINE247	<p>1) The main barrier is money. Too many disabled people are forced to live on benefit-level incomes that do not adequately meet their day to day needs and expenses. Being a disabled person is expensive - whether you need the heating on all the time, have to eat a special diet, or have to pay huge amounts of money for a holiday offering you a helper. The benefits system is also complex and confusing and many people do not get their full benefit entitlement as they find it difficult to challenge wrong decisions, or cannot face the stress. Many disabled people are cared for by their partners and if their partner has to give up work to care for them they will both be living on benefits, and Carers Allowance is so low it's an insult.</p>
ONLINE248	<p>1) Often barriers are caused by the perceptions of other people, rather than a literal interpretation of what a disabled person can or can't do.</p> <p>For example, a disabled person may be a competent professional, able to physically access a place of work, but the potential employer perceives that they will take too much time off work and drain the capacity of the organisation, so someone else is hired instead (but another reason is given). The disabled person is then out of work for longer, giving an added reason for potential employers to hire someone with current experience instead. The disabled person claims benefits 'at the tax payer's expense'. Eventually the disabled person gets a part-time job which is at lower pay grade than they are qualified to do. They have less money than a non-disabled person but not necessarily because they have higher outgoings, it can be just a repercussion of the perceptions of others. I would therefore have some reservations about changes which are based on assessments of increased outgoings.</p> <p>Disability is also an incredibly broad category and so the barriers faced by someone with Schizophrenia are very different from a wheelchair user or someone with a deteriorating condition like MS or a fluctuating condition like ME/CFS. Any attempt to make the form more 'objective' and simpler is likely to disadvantage people with one type of disability or another. Given that 'disabled' is often taken to mean someone who can't walk/see, simpler forms will probably disadvantage those with 'syndromes' which have many different</p>

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	<p>symptoms and are complex. The likely outcome is a higher rate of appeals leading to higher costs for the government and a great deal of stress (which is particularly difficult for people with the types of disability, such as ME/CFS, MS, anxiety disorders, which are likely to fall through a simpler process).</p> <p>2) DLA should still be paid into a bank account! It would also be good to leave it so that what the money is spent on is at the discretion of the claimant.</p> <p>6 different rates for DLA are useful in terms of responding to the variation between different disabilities. More variation rather than less would be better, to respond to individual circumstances and to avoid the issue of being just off qualifying for the next category up. It would be a shame if some current claimants missed out because they didn't qualify for a standard (averaged) rate of care or mobility.</p> <p>DLA is important as a 'gateway' benefit for other things. This should stay the same. Also, if some current DLA claimants lose money under the new system, there should be some system for still getting a certificate stating that they are disabled (in order to get a Cinema Exhibitors Card for example).</p> <p>3) As previously mentioned, I think a bigger issue is that most disabled people have less money than non-disabled people. Therefore, the proportion of their income spent on basic living (rent, bills, food) is much higher. This difficulty may not be related to the level of their support needs or greater outgoings.</p> <p>At the moment the mobility questions don't adequately assess the costs involved for people who can walk but have limited strength or stamina. For example, I get the care component, but not mobility, although the extra costs I face are mobility related rather than care related because I end up paying for a lot of parking/buses for short journeys that I previously would have walked.</p> <p>Costs that disabled people can face are:</p> <ul style="list-style-type: none"> <li>- transport: more taxis, parking (the Blue Badge scheme has a very narrow criteria), public transport and the need to adapt cars.</li> <li>- housing: ground floor flats cost more, adaptations to the home, living in a location close to work or friends/family (limiting the transport problems above), higher fuel bills due to being at home more and being effected by the cold more etc.</li> <li>- care: not just care workers but also a greater need to pay for cleaning, gardening, DIY, babysitters and childcare (friends are less confident and willing to look after a disabled child/ disabled parents may need more breaks) etc</li> <li>- food: people are unlikely to be paying someone to cook (unless they have very high support needs) but limited ability to cook a meal can mean that people have to buy more expensive convenience foods rather than cooking from scratch. They may also need to pay a bit extra each week to get the supermarket to deliver to the house.</li> <li>- getting about: the more obvious aids such as wheelchairs etc (but many disabled people don't require these).</li> </ul> <p>4) I think it would be better to have more variation rather than less. Disability is complex and the assessment needs to reflect this. What will the 2 rates be based on? Will it mean that people currently on low rate Care or mobility lose their benefits?</p> <p>5) For some serious conditions and impairments the implications are fairly obvious. The disabled person will be extremely stressed by their symptoms and limitations and it seems responsible that in these cases they have automatic entitlement.</p> <p>6) There needs to be a holistic sense of what it is to lead a full and active life. It is not simply a case of being clean, fed and safe. People need to be able to access social activities and hobbies of their choice. They need to feel in control of where they go and when. This is also good for protecting people's mental health, to avoid issues around co-morbidity.</p> <p>Also, people need to feel like valued members of society. Something that threatens this is an assumption that people claiming benefits are doing it as a 'lifestyle choice'. Disabled people have a sense of pride too and want to make a 'positive contribution'. The process of claiming benefits can be stressful and depressing and this needs to be taken into account.</p> <p>7) There should be less emphasis on 'a typical day'. This is confusing if symptoms and severity change on a daily basis. Approx percentages over a month and year should be used instead. e.g. can you walk x metres all the time/ half the days in a month/ half the days in a year etc.</p> <p>Also, some people have conditions that are improved for a couple of months and they appear better. However, if they act as if they don't have a disability (walking normal distances etc) they trigger a relapse. This means that current capability doesn't always</p>

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	<p>accurately assess the impact of a particular disability.  There should be more emphasis on talking to GPs and consultants or occupational therapists (in fact the whole assessment could be based on the opinion of these professionals who are experts on the nature of these fluctuating conditions).  Objective measures of disability are going to be particularly unfair for people with fluctuating conditions.</p> <p>8) I see the reasoning with this question, but if someone has to use an adaptation they are visibly disabled and likely to experience more discrimination (and therefore less likely to work etc). They are also likely to be the category of disabled people who experience greater costs around their disability.</p> <p>9) There could be an option for the assessment to be done in person so the disabled person doesn't need to fill in forms.  Repeat forms could be simply asking if the condition has changed - if not no further questions.  The forms could be freer and more subjective, with an emphasis on the disabled person explaining the impact of their disability on everyday life in their own words. There could be an aspect of self-assessment (the disabled person saying what they think they're entitled to and DWP checking this).</p> <p>10) Medical professionals are best placed to provide evidence: GPs, consultants, occupational therapists.  Medical assessments with the claim in mind are likely to be biased against the claimants. Instead professionals who already know the claimant would be best placed.</p> <p>11) If this is their normal GP I think this is a good idea (and could replace form filling).If this is a new person, employed by the DWP, then this is likely to lead to a lot of stress and people will feel like the doctor is trying to trip them up.  People with mental health conditions are likely to find this very difficult and the appointment itself may lead to a worsening of symptoms.</p> <p>12) Permanent conditions shouldn't require a review.  Fluctuating conditions should lead to a copy of the previous form being sent out and the claimant asked to disclose any changes.  There is a legal requirement to disclose changes anyway so yearly reviews are unnecessary.</p> <p>13) There could be an occasional phone call or email to ask people if anything has changed.</p>
ONLINE249	<p>1) for people with physical problems [wheelchairs] access to buildings [shops ,offices,trains etc] is a great problem and only slowly are businesses taking on problem;particular problem in my area [ealing,w5]is ealing broadway station which does not have step free access.  For learning/behaviour problems it is the ability of the people working with tha bisabled that is of concern because bisabilities are not straight forward where you can produce a 'handbook' HOW TO LOOK AFTER PEOPLE WITH DISADLITIES,SINCE IT IS PROBLEMATICAL that all are the same.For people who are autistic there is a wide range of dehaviors that can occur hence 'AUTISTUIC SPECTRUM'.it NEEDS TIME AND care to deal with these disabilities and busness is not renowned for this except firms like REMPLOY</p> <p>1) the main problem could be found to be the idea that disabled people are pushed off denefit without thought to their welfare ,whilst help to get in to work is good excess pressure to get the disabled off benefit for saving money will cause fear amongst the disabled ;who already fear their welfare is not being looked after.Has i've already said if the medical reviews are not carried out in a sensitive manor the disabled will feel discriminated against and real problems will ensue</p> <p>2) THE REVIEW CYCLE I THINK SHOULDbe about 4 years with a possiblity for 2 year reviews</p> <p>3) travel costs mostly for the escort/carer to keep the cared for protected from harm whilst travelling[in my case i have to take my autistic daugther around because she has been badly bullied on buses so WE have extra cost for me to travel with her],and careing costs for me to be with her 24/7 to keep her safe and not to hurt herself or damage home.finally one big cost which is not picked up by councils and government is my time to look after my daugther and it can get raelly depressing to give that 24/7 care !!!!</p> <p>4) For the mobility component two rates seems has it is current should be kept;but the proposed change to care component to 2 levels seems more cost savingf without denefit to the claimants .CARE FOR PEOPLE DOES NOT FIT CONVENIENTLY INTO TWO</p>

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	<p>SLOTS and the middle ground is often where people are'has such the mid band is where my daughter is</p> <p>5) it would be lovely if we could have automatic rights for disabilities but in real world people should be see on review to check the disabilities</p> <p>6) independence and choice has become a by-phrase for disabilities but for my daughter sometimes choice is difficult and actual help with the decisions is what is needed for her and me to help with choice and more social clubs for people with same disabilities and age because they can interreact with each other.In my town ██████████ london we have ██████████ for children and ██████████ up to 25 but beyond that where can she go????</p> <p>7) the review system at present is capable of coping with changes, and has long has the ministry don't slip with the reviews there should not be problem[both my daughter and i have continuing reviews</p> <p>8) this is not within my knowledge</p> <p>9) the form should provide for open answers not pre-picked on the form[we are dealing with people not ticks]and the name change from dla will cause confusion.the benefit is not automatic and has to be applied for</p> <p>10) doctors/nurses/ot/cares should all be included but recently there has been problem with some doctors are charging the disabled for letters that puts another burden on them for more money</p> <p>11) there are already review checks with professionals arranged by local medical centres[ours being in wembley]so i find it hard to understand where this question comes from,yes there maybe a small number of people not reviewed regularly but this will be up to the local medical centre under dwp control</p> <p>12) the review system at present is working well it has balance of documents and visual meeting and testing.the important thing is that in the review the reviewer should be testing the disabilities not saving money willy-nilly;My own case was such that the doctor tried to say i did not have high blood pressure by doing a bodged pressure test which on complaint the decision was changed and my high blood pressure noted</p> <p>13) the current review cycle of 4years should be used and if the medical team feel closer control for some 'dodgy 'cases the review should be done on shorter time frame</p> <p>?) has i and my daughter do not use aids except special insoles which help her walking/balance which were free but i did offer to pay and i think people will fund things through there dla and /or other benefits</p> <p>?) i do not see any idea that dla would help .the medical team can make help available to disabled and in certain cases of physical disability has can be seen from news on our badly injured soldiers new legs /arms etc can be used but ?who funds those costs?</p> <p>?) I can not see where you are going with this question but dla or the new pip would not directly help the normal service providers would be within NHS[ gps and hospitals of physios etc] or social care /social services with day centres training.firms like reemploy help but they seem to be floundering.DLA and PIP are there surely to make certain that people with disabilities can have food.shelter and warmth with the further object to provide for any medical social help ;and thence if possible to allow these people access to work that they can do</p> <p>?) information packs could be used,but linkage to the disability and the idea to the disabled that they could lose benefits[money] could have adverse effect on causes people to have depression and stress adding to nhs costs with medical help</p> <p>?) the basic idea is 2 components care and mobility.</p> <p>the mobility is to see how much a person is capable of moving ;whether great difficulty or less .</p> <p>the care is to see how much care is needed.</p> <p>this then will provide for the person with disabilities the means to aid in independent living ;this does not mean automatically that a person will be independent but a means down the road to that end.In my experience [i'm a volunteer at local carers centre people with wheelchair disabilities don't get out of their chairs and walk nor do people with mental health problems move into normal jobs they usually find jobs in organisations which deal with these disabilities!!! But when the medical staff do the review they can refer disabled to groups to help with their disabilities ie mobility to ot/physio/ wheelchair organisations and care to the different care groups.</p> <p>finally info to be held ;nhs and gp's hold most info with social services and these sources are referred to on the review</p> <p>?) the idea for help towards people with disabilities is good and the possibility of help for</p>

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	<p>working is good but no discriminations must be allowed and the disabled looked after  ?) the major think has far has mental health is that there is [has i've been told by hospitals]that childrens brain patterns are different from adult and should be looked at from that point of view.whilst with pysical problems again the stage of development must be taten in to account  ?) the usual things would be transport cost and arranging transport to doctors,hospitals and other medical appoinments.these costs are not fully seen thro 'modility' component ,certain problems include escorts to help people get out of the house to go to these appoinments.'dial-a-ride and taxi card' don;t allow their drivers to act has escorts so usually medical ambulances do job.costs also hidden and knowledge of wheelchair repairs not seen by wheelchair users and then if wheelchair brakes down user in then housebound and the medical .social/employment goes up the creek</p>
ONLINE250	<p>1) My son, mum and I are disabled - my son has brain damaged, my mum has osteoporosis, and I have badly damaged knees after an RTA. We have many similar problems, but I don't need a carer to look after me. The biggest problems are the same - how to get to, and participate in, things which a normal person does without thinking. The shops, hair dresser, work etc. etc. None of us can do it without personal transport - we can't use public transport.  I can't work because the pain is too intense - but I'd live to work (I have a degree in Business Studies and excellent keyboard and "people" skills)  2) Recognition of different levels of support for different needs - my son needs someone to help him because he has severe learning difficulties, although he can walk well. My mum needs people to do almost everything for her, dress, make a cup of tea, prepare all her food etc. I just have bad knees which are so painful I can't walk fa.  3) MOBILITY!!!  I'm intelligent, qualified, would love to work but can't due to pain. I can't use public transport at all - I can't even walk to the bus stop half a mile away in a rural area. I need a car for absolutely everything.  HEATING  If you can't move about your body doesn't generate it's own heat.  THE NEED TO GET SOMEONE ELSE TO DO THINGS  I can't decorate, mow the lawn, go shopping at the cheapest stores etc. etc. simply because I can't walk. My mum needs someone else to do everything for her, even dress and make a cuppa, because she is so physically frail. My son needs someone else to support him because he can't understand things, read, or handle his own money.  4) I'm generally in favour of different rates.  5) Yes, some things should entitle someone automatically.  IMPORTANT OMISSION  You need to have a short term allowance for those having knee/hip replacements. These give long term benefits but it takes a long time to get back to normal. (I've had one, need another). In the meantime, I cannot work or walk as normal and the effect on my life means I cannot work at all)  I DO NOT NOT NOT AGREE with withdrawing DLA mobility allowance from those in care homes. This may be OK for elderly people at death's door but it certainly grossly unfair on young people with learning difficulties. My son was in one for years before moving into Supported Living. He was charged mileage if he used the home's transport for anything. No DLA = no journeys - so how is he supposed to get to the doctor, dentist. £20 a week residential care cannot pay for journeys as well as clothes, shoes and anything else. This is the WORST POSSIBLE IDEA AND YOU AREN'T EVEN CONSULTING ON IT.  DISGRACEFUL.  6) Look at Maslow's hierarchy of needs. Shelter, food and drink come first, plus access to health care. I've never got further than these needs since the car accident which ruined my life.  7) Change the assessment system. The doctor who came to see me was more concerned about clock watching than me, refused to listen to many of my answers, didn't record things properly, and answered questions on the form without asking me! It took 6 months for me to get his refusal decision overturned. In the meantime no DLA, no disability working allowance, and I had to pay my own car tax - with no income whatsoever!  8) This question is very foggy - what do you want us to write?!</p> <p>Surely the key thing is the ability to walk. Don't deny someone DLA just because they use</p>

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	<p>a wheelchair. Don't deny them DLA because they don't either. I'm struggling to keep out of one on a day to day basis, but use an electric one to go round country shows. The aid I do or don't use is irrelevant, it's the ability to walk that counts.</p> <p>9) Firstly, put the form online, like this one, so that there is plenty of space if required and the entries are typed tidily, not scrawled (my writing is not good!)</p> <p>At the moment, DLA mobility depends on how far you can walk, but the form doesn't actually focus on that. If you are entitled if you can't walk more than 100 yards, then say so clearly. Then get the assessors to focus on that, and get the people reading the forms to focus on that. They didn't in my case - it took me 6 months to sort that out!</p> <p>10) As previously said, my assessor was a disgrace. I'm a former social worker and it was a classic case of how NOT to assess someone, sticking slavishly to each question, constantly interrupting me when answering, then in the end ask if I wanted anything else to be taken into consideration, when I'd been trying to give him these for the previous 40 minutes. Simply giving an applicant a copy of the questionnaire beforehand so that they know what they are going to be asked would be a good step forward.</p> <p>11) It depends on the healthcare assessor. For example mine was very critical on his form about the untidiness of my lounge, but didn't say anything to me about it. I too hate the untidiness of my lounge - but how can you tidy up properly when you are in constant pain whenever you walk. I'd love a home help to keep it clean but can't afford it. As a former social worker I think someone's house can be a good indicator as to how they are coping. I'm not!!</p> <p>12) Those with established long term conditions - like my son's brain damage or mum's osteoporosis - should have life time awards at the highest level.</p> <p>Those with conditions which can get better should possibly be reviewed every so often.</p> <p>13) I think it would be better to make fixed term awards (bearing in mind the fact that someone has been assessed as being disabled for a given period by the DWP. It is up to the DWP to work out a proper review period and then either sent a simple form asking if anything has changed towards the end of the period.</p> <p>I am keen to see a system in place where someone who is entitled to a benefit has it stopped suddenly because the DWP took so long to look at the review form, and then didn't read it properly. No excuse. Make an award for a set period.</p> <p>14) DO NOT MIX BENEFITS AND HEALTH ASSESSMENT. This would be an absolute minefield. By all means make suggestions if appropriate, and signpost. The doctor who came to see me wasn't even capable of filling in a form properly.</p> <p>15) This is a foggy question. Was the questionnaire writer getting fed up?</p> <p>A benefits review is about benefits. Forcing claimants to take action sounds like a police state. Concentrate on whether the person in their existing situation is entitled.</p> <p>16) At the moment I pay for all my aids etc. I'd love entitlement to PIP to mean that the govt. would pay for these instead?</p> <p>How claimants use their PIP is up to them.</p> <p>17) As the mother of a disabled child, we survived on my son's benefits because no one else could look after him, so I couldn't go out to work. Even using the Local Govt. Ombudsman failed to get the Social Services Dept. to give me even the respite care I'd been assessed as needing. I got no support from ANYWHERE. Just assess the child on what they need. School holidays, especially in the summer, are an absolute nightmare for parents when they get no break during school hours. When a disabled child is home and awake, you have to keep an eye on them constantly, so housework, admin. etc. has to be done during school hours.</p> <p>?) It would be an absolute nightmare. I've spent 30+ years giving details about my son's disability again, and again, and again.....</p> <p>?) I'm not sure. This sounds like Big Brother to me.</p> <p>?) Yes.</p> <p>?) It is very important.</p>
ONLINE251	<p>1) It is really important that the person is given as much information as possible regarding access to other entitlements, especially motability as this can give a person the independence that can make a very big difference to their life.</p> <p>10) I think the best people to give a clear assessment are the GP and if the person has a carer then that person needs to speak about what they have to do and report supporting evidence.</p>

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ONLINE252	<p>1) The main barrier is the person themselves - DWP research paper 648 showed that attitude of the disabled to participation in community and in work was often curtailed once the disabled person had become reliant on DLA as a means of income.</p> <p>I have care for a brother with mental health problems and in receipt of DLA. DLA is his main income but provides such a high level of disposable income because of his non integration or lack of motivation to go to work that instead of shopping and being part of the community he can afford to purchase ready meals and takeaways increasing his own cost of living but staying within the parameters of DLA.</p> <p>He is highly qualified with two degrees and has worked previously in responsible jobs for large employers but has drifted over the last 10 - 15 years doing lowpaid manual work. He now says he is to "feeble" to work but as part of his rehab he did undertake for a short while some reception type work for the local social services. However that job dried up and there is no pressure from his current social worker or PCN for him to go out and find work or undertake voluntary work in the community. They seem to prefer to take him to cafes for "social intergration/interaction" which does not happen and seems to be a waste of time and resources and only serves to increase his social isolation.</p> <p>This is a prime example of the care those with mental health issues receive acting almost in opposition to their need to be involved in society. The effect of DLA is that it provides the means for such people not to have to work or become part of the community they live in. DLA should be linked to a care plan or to voluntary community service suited to the capability of the DLA recipient, even if there are mental health issues involved, so that at least there can be some mutual gain for the disabled person and the community they live in for the money paid out in DLA benefits</p> <p>2) It should remain a non means tested benefit.</p> <p>Apart from that the system clearly needs to be seriously overhauled as I do believe there are too many inconsistencies that arise from using non-qualified decision makers and from having no real power to review cases. Many DLA decision makers seem to be incapable of following their own departmental advice as to what care and mobility regimes one would expect to relate to individual illnesses or disabilities - the sense of post code lottery often is felt across disabled groups and is probably a reality because of the lack of a willingness to impose some consistency into DLA award process.</p> <p>3) This depends very much on the standard of living the disabled person is accustomed to or wants to have.</p> <p>I feel that current rates of DLA in most cases are more than enough to meet the needs for which they are intended especially as they are non- means tested.</p> <p>However where there are cases of DLA entitlement being more than enough for some customers I am sure other customers will demonstrate that their total income including DLA will not meet the needs arising from their disability.</p> <p>I note that one solution proposed could involve HCPs deciding on an individual basis what rate of PIP should be awarded but this again will probably cause complaints of post code lotteries etc.</p> <p>There needs to be some sort of account taken of the standard of living enjoyed prior to the claim to DLA/PIP and perhaps a needs test to ensure that the award is commensurate both with the degree of incapability suffered and the standard of living enjoyed.</p> <p>4) I am not sure how far this changes the existing system where benefit is awarded on care and mobility assessments.</p> <p>Is the fact that a HCP may undertake this assessment the difference? Or perhaps my earlier point concerning a need not to be less prescriptive that a particular incapacity/illness must relate to a particular level of care and/or mobility need is more appropriate.</p> <p>I feel that there is a need for much more targeted assessment of need than we have at present and if the HCP examination achieves this then so much the better.</p> <p>In terms of having two rates this will inherently have the same problems that are manifest in DLA now.</p> <p>It is not the fact that there are two rates - there could be "x" number of rates awarded in any combination- but rather the fact that there is not always a clear line of reasoning as to why person A with condition C gets £x whilst person B with the same condition C gets £x+1 or £x-1.</p> <p>Perhaps the proposed move to linking rate of component paid to individually assessed need is the way forward but this will be costly and will not address the very key fact exposed in research paper 648 that there has grown up a separate advice industry which encourages the use of maximising conditions/problems and difficulties related to an incapacity to</p>

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	<p>secure most reward.</p> <p>5) This is a difficult question to respond to in that it has implications both in terms of whether DLA or PIP should remain non-means tested and whether or not a diagnosis is enough to provide an automatic right to a level of care.</p> <p>If the intention is for PIP to remain a non-means tested benefit then there is absolutely no reason why there should not be a list of conditions that automatically give entitlement (even after a qualifying period). However this on its own will only promulgate the problems inherent in the existing DLA system which would award benefit on the diagnosis alone and would not take account of the individual needs of the person.</p> <p>My point here can be exemplified as follows: Two people with schizophrenia may automatically qualify on the basis that they have a severe mental health condition. One may be perfectly able to live in the world without care during the day and only marginal care at night whilst the other needs constant supervision. Based on diagnosis alone both will receive the same rate of DLA/PIP on an automatic award basis because of the impairment even though clearly one has less of a need than the other.</p> <p>If the person with the higher care has a substantial substantial income or capital whilst the other has a job at the Minimum Weekly Wage because of their condition should this affect the assessment of DLA/PIP entitlement?</p> <p>The latter's care needs are lower but their financial need is higher should they be refused on the grounds of lower care need or be awarded on the basis that the impairment restricts their ability to earn a higher wage in the market place? Equally the one with higher care needs but significant financial resource does not really have a need for additional financial support so should we refuse to pay benefit?</p> <p>Remaining in the non-means tested basis for this benefit will always mean this sort of question occurs and will mean that inequality will continue.</p> <p>However moving away from a non-means tested approach will raise questions that one should not be discriminated against because they or their family have made appropriate financial arrangements.</p> <p>On this basis I do not believe that there should be any automatic entitlement grounded purely on the nature of the impairment but that entitlement should be decided purely and simply on the scale of impairment and care needs decided not by self assessment but by a HCP.</p> <p>6) This should be based solely on an assessment of the condition by a professional person with a view to establishing what constraints the impairment has on the person's life. This should involve an assessment of how the claimant's life differs to someone who considers that they have no impairments and are "perfectly fit and able to live within society without any additional help"</p> <p>The current DLA criteria is difficult to understand and almost impossible to assess by a normal person. The claim form is repetitive and clearly written by civil servants who have a business agenda in mind rather than trying to get to the real need that a person has. It seems to be an assessment of the impairment symptoms and causes against a medical standard rather than trying to establish what a real individual's needs are. Two people with the same impairment should get the same DLA at the moment but, depending on their own view (pessimistic or optimistic) of their condition, there is no guarantee this will be the case.</p> <p>Therefore the current system is wrong in that it is testing against a standard of disability when we need to test against the standard of no disability irrelevant of the impairment. In other words test the "what can you not do" against the "what you can do" standard one would expect from an able bodied person and do not allow any automatic entitlements based solely on impairment.</p> <p>7) By regular review by appropriately trained HCPs</p> <p>8) I think that we need to test against the normal not the impairment therefore we should then be testing the ability of the claimant based on the aids and adaptations they have and this should be against a professional view of what aids and adaptations could be made to improve ability to manage.</p> <p>The assessment therefore should look at the rounded picture of what the person has, what they could have and if they had it would their care needs remain the same or reduce? If it reduces then test that level of reduce ability to decide if benefit to make good the difference should be awarded.</p> <p>9) The claim form should be simply a means by which a claim is registered it should be limited to necessary contact details and the nature of the impairment that is causing the</p>

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	<p>care issues.</p> <p>We should then undertake an assessment of need, carried out by a professional service made up of care experts rather than civil servant decision makers, even if this means more visits to people at home. This may be more expensive but will improve the accuracy of award, will ensure that exaggeration is removed as much as possible, and ensure we allow entitlement based solely on a professional view that there is a need.</p> <p>10) By using a Professional assessor the need for evidence apart for the assessment itself should be removed</p> <p>11) See responses to the questions above. I think this is a vital improvement that has to be made and there should be absolutely no circumstance where it would be inappropriate to require a face to face meeting if this is considered essential by the assessor. If the claimant refuses such a meeting that should be enough to halt the claim</p> <p>12) Again the award of the new benefit based on care needs has to be systematically and properly reviewed. Again I think trying to make a review cycle based on the impairment is "x" therefore the review period is "y" is wrong.</p> <p>Part of the initial assessment and subsequent reviews should be an individual assessment of whether or not there is likely to be an improvement given additional aids that the award of the benefit would bring, or is the prognosis that the impairment is chronic and likely to be attritional therefore the review would be more frequent and the rate of benefit likely to increase. If this is not the case then the review may be as often but would be looking for improvements that may see the benefit rate reduce</p>
ONLINE253	<p>1) This is a question that is beyond the scope of DLA.</p> <p>Insofar as lack of income is a major barrier, and we believe that it is, then DLA is relevant. As with other groups in society, access to work and status within work are usually significant determinants.</p> <p>2) The proposed reform is very limited. The desire to target support to those most in need and to simplify the benefit is laudable but we doubt that these limited proposals will make much difference or indeed halt the steady growth in claims and expenditure.</p> <p>For example, the growth in claims predates the introduction of the social model of assessment in 1992. For example, Mobility Allowance claims trebled in the decade from 1979 to 1989. This was when there was only one component and when all claims were medically assessed. Therefore, the return to a form of medical screening of claims is not guaranteed to lead to improved targeting of the benefit or a reduction in claims.</p> <p>Having a benefit with 2 components and 5 rates is clearly confusing. But the proposal would leave this structure more or less intact, ie abolishing only 1 level and retaining the 2 components. Therefore, this will have only limited impact.</p> <p>We propose that the reform is bolder and more fundamental whilst retaining the concept of a benefit payment that assists the most severely disabled with the added expense of disability.</p> <p>3) One of the main weaknesses of DLA is that it is focused on 2 elements, care and mobility and excludes people whose disabilities impose cost of other kinds, eg certain digestive disorders requiring more expensive diets.</p> <p>From our experience, the main costs that disabled people face include heating, diet, laundry, equipment and informal assistance.</p> <p>Mobility may not even be an extra expense for some disabled people currently in receipt of mobility component because of assistance available from, for example, social services and because they are not mobile anyway.</p> <p>It seems to us that there is still uncertainty as to what the extra costs of disability are. Indeed, that fact that we are being asked this question as part of this consultation bears this out.</p> <p>The proposed reforms do not address this and will perpetuate the narrow focus on care and mobility.</p> <p>4) As we have observed, the proposed reform is very limited. Reducing the number of components from 5 to 4 will make very little difference to simplification. Other sources of confusion, such as the age cut off, are retained under these proposals and will perpetuate the problems and costs associated with this benefit.</p> <p>The retention of 4 of the current five components will have only limited impact.</p> <p>The existing benefit with 5 components is complex, especially as effectively claimants have to choose whether to apply for one or both components. This reform is an opportunity to sweep this structure aside and achieve real simplification. There are precedents from</p>

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	<p>elsewhere in the benefits system of a single assessment leading to an award of benefit based on a sliding scale, eg War Injury or Industrial Disablement. For consistency, transparency and ease of administration, certain disablements could automatically attract a prescribed level of award</p> <p>The disadvantages and criticisms attached to the existing scheme will pretty much apply to the proposed structure as it is very similar to what we have already.</p> <p>5) We acknowledge that automatic entitlement is a response that some decision makers are uncomfortable with, particularly because it can be said to fail to take into account individual circumstances. However, automatic entitlement can be a cost effective and consistent way of assessing disablement and is used elsewhere in the benefits system. Automatic entitlement avoids the current problem where 2 people with the same disability get different awards of DLA.</p> <p>6) There is an issue here that is to do with whether the benefit should be targeted to those on the lowest income, or those with the greatest additional cost of disablement. It is not clear from the proposals what the government's priority is. An obvious way to prioritise support to those least able to live full and active lives would be to have an assessment that attempted to measure disablement broadly then paid the highest affordable level of benefit to those who have the highest level of disablement. This is based on the reasonable assumption that the more severe the disablement, the greater the disadvantage in terms of living a full life. The above single assessment could be accompanied by some form of means testing or by making the benefit taxable to further prioritise the benefit to those most in need. The continued exclusive selection of care and mobility needs in the proposed PIP to the exclusion of other activities perpetuates the problems previously referred to.</p> <p>7) The current benefit rules and established case law precedents provide for this and no further change is needed.</p> <p>8) The benefit rules currently provide for decision makers to take into account aids and adaptations as appropriate and we do not see that there is a need for change in this area. Misunderstandings arise currently when decision makers presume that the use of certain aids/adaptations would obviate the need for personal care/supervision without a professional knowledge of the availability or applicability of the aid/adaptation to the individual concerned.</p> <p>10) The notion that there is "killer" evidence out there that will somehow provide the decision maker with an easy assessment is an illusion. In reality, the assessment of disability is subjective unless the claimant falls into certain pre-defined categories.</p> <p>11) Is there any evidence that the claim outcomes will be any different where there is such an assessment? It is implied in the consultation document that this will somehow improve the "gateway" and that there will be a reduction in unsuccessful claims. Why should this be? As we have already pointed out, awards of both Mobility and Attendance Allowance were rising through the 80s, ie when there was such a face to face discussion as part of the claims process. In our experience, as many people understate their disability as overstate it when carrying out a self assessment so these things will even themselves out. Whatever are the reasons for the rising number of DLA awards, there is no evidence that a face to face with a health professional will halt this. Of course, there will be additional cost not only in terms of the cost charged to DWP for the face to face; there will be additional cost of administration. In many cases, too numerous to mention, entitlement or non-entitlement should be obvious and the assessment will be an expensive waste of resource. However, despite the above reservations, it is also a fact that many people find the current application form for DLA very difficult to complete and would welcome the opportunity to describe their disability to a professional as an alternative. It has to be said that the professional would need to have an excellent working knowledge of the range of disabilities and understand people's individual requirements. The professional would need to be sympathetic to the effect the interview may have on people and be prepared to work patiently with people to get the full information they need to make a fair decision.</p> <p>12) The criteria for arranging reviews and their frequency need to take into consideration individual people's needs. Also, consideration needs to be given to administrative cost and efficiency. People with certain disabilities are not going to experience any significant change therefore, review is not cost effective.</p> <p>13) Will it really be easier to understand? The reduction from 5 to 4 components will make little difference. That and other features such as the retention of the age cut off at 65 will</p>

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	<p>carry forward the incomprehensibility of the current scheme.</p> <p>A common source of overpayment is the overpayment that arises on admission to hospital/residential care for 4+ weeks. Many claimant are understandably preoccupied with their health at a critical time and fail to notify. Better information sharing would reduce this source of overpayment.</p> <p>?) As previously stated, we are not convinced that these proposals will succeed in improving understanding of the benefit. Nor are we convinced that removing automatic entitlement for certain cases will improve consistency. In other respects, we are sceptical that these reforms will achieve their aims and the law of unintended outcomes will apply to these changes, making the impact assessment little more than guesswork</p> <p>In order to adequately assess the impact of these proposals we would, need to see a profile of the gender and age breakdown of the current recipients of the lowest rate care component as this is the cohort most likely to be disadvantaged by the changes.</p> <p>?) As previously stated, we are not convinced that these proposals will succeed in improving understanding of the benefit. Nor are we convinced that removing automatic entitlement for certain cases will improve consistency. In other respects, we are sceptical that these reforms will achieve their aims and the law of unintended outcomes will apply to these changes, making the impact assessment little more than guesswork</p> <p>In order to adequately assess the impact of these proposals we would, need to see a profile of the gender and age breakdown of the current recipients of the lowest rate care component as this is the cohort most likely to be disadvantaged by the changes.</p> <p>?) Is there any evidence that this would be cost effective? We have not seen anything and we do not have any experience, from the vast number of DLA claimants we advise, that there exists a noticeable number of people who wilfully ignore available help in the way that the question implies.</p> <p>?) On the one hand, this may increase administration costs if the consequence was a requirement for an additional assessment. On the other hand, it may allow for a more tailored approach.</p> <p>?) Of course, most children receive high levels of personal care whether they are disabled or not, which makes the benefit very difficult to apply because of the exclusive reliance on care and mobility needs. The proposed reforms will not change anything because the focus will still be on care and mobility. I</p> <p>A bolder reform of DLA that attempted to make a wider assessment of disablement and awarded benefit on a sliding scale would be an improvement because it would mean that the allowance more closely linked to the additional cost of disablement instead of just focusing on 2 elements, care and mobility.</p> <p>?) On the one hand, this may increase administration costs if the consequence was a requirement for an additional assessment. On the other hand, it may allow for a more tailored approach.</p> <p>?) People already use DLA for a wide variety of expense including one off costs. This includes saving for what is required as a one off cost and budgeting for ongoing costs. The government should give people as much freedom as possible over how they spend their PIP/DLA.</p> <p>?) See comments at 13 and 15.</p> <p>?) The administration of current passporting arrangements often requires checking between departments. For example, LAs must check entitlement to higher rate mobility component as part of the process of awarding the blue badge parking concession. This would be more efficient if LAs had access to DLA client information.</p> <p>?) The conditions of entitlement to the various disability benefits and services are not aligned and this creates a fundamental problem with combining assessment information. It is well established in case law that decision makers at all levels should apply themselves to the statutory test and the dangers of departing from this are plain to see.</p> <p>?) These proposals are a great disappointment and nearly all of the problems of the current benefit will be carried over to the reformed scheme.</p> <p>Presumably the withdrawal of the lowest rate care component will achieve a cost saving but we doubt that the proposals will do anything to halt the current upward trend in DLA claims and certainly not achieve the 20% cost reduction desired by government. Not enough is known about the reasons for the upward trend in DLA awards and, previous to 1992, Mobility Allowance/Attendance Allowance</p> <p>Further, these reforms, in our view, will fail to either simplify or improve targeting of this benefit to the most severely disabled people.</p>

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	<p>Finally, DLA as with the benefits system in general, can now be said to lack integrity because we have means testing as the mechanism to target, for some groups but not for others.</p>
ONLINE254	<p>1) I live in a rural area. So there are restrictions in terms of the availability of public transport and physical access onto buses and trains. It is impossible to get a taxi in my town at the start and end of the school day as they are all tied up in getting children to school. This means that you are limited as to the times that you can do things. We have accessible community transport but it is only available weekdays 9 to 5 - so again, you are restricted in what you can do when. The biggest problem I think is that it is all just too very, very hard to get out and lead an independent, full and active life. It could be easier - so for example I used to go swimming but I get so tired just getting changed that I have given up. I would love to have someone just carry my bags and help me get changed. I would like to go on holiday - but again the practicalities are all so huge - from finding a room that is wheelchair accessible to asking someone to carry my bags.</p> <p>2) I think that I will say this here. I am a bit concerned about DLA not being means tested. As someone who was involved in an road traffic accident that wasn't my fault, I have compensation. This will need to support me and my continuing and increasing mobility and care needs for another 30 years or so - and I need to make the best use I can of my money. However, I am also realistic and the Government needs to make best use of its money as well. Some people may not need DLA.</p> <p>3) Getting around - in whatever form that might be: taxis, mobility scooters, motorised wheelchairs (and associated maintenance and insurance costs) Support for Personal care - washing, dressing, medical intervention Support to enable you to live at home - home help for doing the washing, cleaning, ironing, Support to maintain the house and garden to an acceptable standard (like anyone else would) - painting, decorating, general maintenance Medical care - getting to and from hospital, doctor and medical appointments, incontinence pads, prescriptions Medical care not provided by the NHS that helps manage the condition - hydrotherapy, speech therapy, Functional Electrical Stimulation, Physiotherapy, Occupational Therapy Alternative therapies that help - acupuncture, massage, Someone to manage the emergencies - Careline, changing a fuse, changing a light bulb, changing bedding after an incontinent night Specialist equipment - always things cost more Holidays and nights away - the need for accessible rooms means that people with physical impairments can't take advantage of cheap room rates. Accessible rooms never seem to be dicounted - if they are available in the first place. I can do very little for myself around the house or garden. I think that it is important to keep friendship separate from living my life as someone with physical impairments. As a reuslt, I won't ask friends to do things for me - I need to pay people to do things - like change a light bulb or weed the garden.</p> <p>4) If the focus remains on removing barriers and enabling people with impairments to live full and active lives - like anyone else can - then I don't see any problems with just having 2 components and 2 rates within each compnent.</p> <p>5) I would support the focus being on the impact of the impairment - however, this is not as simple as it might seem. There is a fundamental flaw in considering DLA within a simple Social Model of disability. People with impairments, in general, do not celebrate their impairments in the same way that people who are from ethnic minorities or who are lesbian gay, bisexual transgendered are encouraged to do. Instead, people with impairments spend their time trying to prove that they are as good as those members of society without impairments. As a result, some people with very significant impairments achieve greatly - but the personal physical costs can be high. People with impairments are different and we should be encouraged to celebrate the difference and not feel all the time that we have to keep pushing forward. This means that the standard that we are to be judged by needs to be individual €“ based on what we want to do with our lives €“ rather than what is prejudged and predetermined by others.</p>

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ONLINE255	<p>1) Due to my brain haemorrhage in February 2010 I am still experiencing horrendous fatigue plus cognitive problems. I would love to do some work, although I am unable to return to my old job. I'm sure I'm not alone: show me the employer who will understand that my energy levels fluctuate so wildly from day to day that I can never say when I'll be up to anything or when I'll need to spend 48 hours in bed recuperating. I am not even "disabled" in the commonly held sense of the term, yet I feel very discouraged about going back to work with my health issues the way they are. With so many people out of work, what employer is going to choose a disabled person over an able person?</p> <p>3) Personally, my biggest problem is not caring for myself at home - with care and taking my time I manage all by myself. However, I have trouble getting public transport and there are places that aren't served by the local bus service (eg council, library etc) and I can only access them by taxi which is beyond my budget as I'm on ESA. Medication is also a HUGE cost, but I'm lucky that I'm on a medical exemption certificate due to a condition that pre-dates my haemorrhage.</p> <p>5) I feel there should be some conditions that automatically entitle you to the benefit when the condition first hits, even if you then have to have follow-up at a later date to see the person is faring. In my case, I was temping, and the sole breadwinner when my bleed (=stroke) happened. I was in hospital for six weeks, leaving my partner and daughter without any income at all. We then had to jump through hoops to get ESA and I was turned down for DLA. Having the benefit kick in sooner and automatically would help tide people over when they most need it.</p> <p>11) This is one point I feel very strongly about! The current ESA medicals, carried out by Atos Healthcare, are a farce. The questionnaire is biased so that nearly everyone is found fit for work; people are seen by midwives and nurses instead of doctors; if you do see a doctor, the doctors that work for Atos are not very good quality (I worked previously in the NHS, I know a LOT of doctors, both good and bad!); the "healthcare professional" you see knows nothing about your condition but is supposed to judge "how you cope on the day of the interview", which in cases like mine can be extremely variable from day to day. This is, apparently, so that each case is examined on its own merit but really it just means that everyone "fails" the medical even when they have serious issues. Your own GP or Hospital Consultant's advice is over-ridden by a 15 minute interview with someone who knows nothing about your condition. How can that be right??</p>
ONLINE256	<p>1) Peoples attitudes and money will not remove the stigma that disability still has in todays society. Reforming DLA will is not the right move for thoses people who have been given awards for life and now will have the stress of being reassessed once again something i had to undergo both in my childhood and in my adulthood and was born with my impairment, its genetic, something i was born with. I will never get better so stop wasting my time the cost of paying for me to undergo yet another medical assessment as well as tax payers money. I should not have to prove my disability.</p> <p>Other barrriers are the high costs of specilist equipment that i have ot pay high costs for. Society still does not value disability which is reinfreced by the media attitude, no positive roles models. i could go on .....</p> <p>?) peoples attitudes ar the barriers, lack of positive role models, money, access to services need i go on</p> <p>?) Popel will be treated differently</p> <p>?) most disabed people find out from each other what they are entitled to. I still have not read how the new proposed benifit will compare to DLA and what about thoes ppeople such as myself lease a car and have doen for some time.</p> <p>2) For these people who have been given life awards and who are on both high rate of mobility and care should not have to be reassessed. Espically when tney are born wth there impairment, it digrading and unnecessary.</p> <p>?) WE would not have access to thing that we do now.</p> <p>3) heating, specilist equipment, fuel, diet, medication as i have to pay for all my medication. alterations to clothing</p> <p>?) There is no overlap with my case.</p> <p>4) you are just tryig to get your budget reduced for DLA and will be hitting thoses people who are already receiveing it under a lifetime award. there has ben little informaiton about the reforms that are going to take place. Ther is not clae informtion about how the rates related to the current DLA rates.</p> <p>5) Again i have a disaility that i was born with and will never be non disabled and have</p>

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	<p>been awarded a lifetime award after many medication assessment so feel that i should not have to undergo a reassessment again to prove i have something that i will not be grow out of.i understand that it will need to be looked at if a perosn has impairment that they have acquires/ developed, use your common sense it someone is born with there disability then leave us alone and if someone acquires ther imapairment and eg spinal injury/brain haemorage they they will need to be supporte.</p> <p>6) being able to get out and about , having access to a an adapteed car, working, running a home, social aspects of life, being able to pay bills interpendently.</p> <p>7) As disabled people awhat they think and list to what we ahave to say and act up on what information is given to you with out making it harder for disabled people to recieve the finacial assistance espically for thoes of us who do work and recieve DLA</p> <p>8) Everything should be included as we as disabled people have adapted our lives accordly to our environment. Some people may not have all the aids they need and don't know where to get things from and can afford the costs of the equipment either as they work.</p> <p>9) There is not claer information about the proposed changes and like mysef many disabled people are scared that they will loose there benefit which will have a dramitic effect on disabled peoples lives. this exercise is a way of reducing costs not about making the process easier for disabled people. You have proved this by only allowing a short time for this consutaion and again seeeking responses on this website which is not accessible for alot of disabled people.</p> <p>10) Im a tryed of being reasses and my disability should not be questioned as they will have no knowledge of my impairment as its very rare so they will not have any knowledge about my disability so they will not be helpful.</p> <p>11) No benifit for me. I dn;t want to have explain tosoemone who does not the knoweldge or expereince about my disability as they will have rarely met anyone with my impairment so how can they make an assessment about my disability.</p> <p>12) For those people with lifetime arades should be left alone under the currelty DLA benfit,.</p> <p>13) Don;t penalise those people who have kept you update date of any changes. For thises people who have newly applying for the benifit should be reviewed regually to snsure they recieve/ don't recieve the money they are entitled to.</p> <p>14) thoses disabled people who work currley do not ofent recieve any other benifit as they earn more that the state says we need so how will this new process help thoes people!!</p> <p>15) not to assume that disabled peole do not know where to get help, dont patronise us as there aresoem disable people who manged there lives including working fine by themselves.</p> <p>16) AS i work i have to pay for any equipmment that i need, shouldn't equipmewnt be provided by the state so in other words the spending cuts will meant that this new benefit wull mean that this benifit will have to pick up the costs whcih does not make sense ther is only 1 pot of money at the end of the day!</p>
ONLINE257	<p>1) The main barrier or problem is the dissability itself. and the able bodied understading of it. There will always be a need for assistance for a disabled person but this must be at the disabled persons request not the able bodied decideing for themselves what we need. The classic case is the blind person standing at the side of the road then being helped across the road by the well meaning sighted person. The lind person then politely asked to be taken back so that they can then stand in the right position for the expected bus to then open its doors in front of the of the waiting blind person. The well meaning able bodied are the ones who need educating.</p> <p>2) DLA should not be means tested. If you have a disability no matter how wealthy or poor you are you should be treated the same. Disabled Living allowance is provided to help us buy the extra things we need to live as normally as possible.</p> <p>3) As a visually impaired person I need talking items such as weighing scales and jugs in the kitchen. A little gadget called a liquid level indicator to let me know when the 'boiling' water from the kettle has reached the correct level in the mug or cup. Otherwise I could easily scald myself. There are many talking items to help with reading but some are over £1000 making them quite out of reach for somepeople. DLA helps toward these things in a small way.</p>

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	<p>4) Two components are all very well but this usually means that you are answering the same question twice over. The help is needed at all times. Care and mobility sometimes amount to the same thing when you need a guide to make sure you are not trying to use the wrong item in the bathroom, assistance when out in the street so that you do not walk straight off pavements or fall down steps.</p> <p>5) As a visually impaired person DLA at present is automatic although we still have to apply which of course mean getting someone to fill out the form. Blind people fall into varying categories. Someone born blind will be quite able to lead what appears to be a very easy life. Those of us coming into this frightening situation later in life have a great deal to adjust to and DLA helps with the various aids that make independence easier. We still need help no matter how independent we want to be. Just because we can walk doesn't mean we can get around easily and many of us do not want a guide dog.</p> <p>6) The ability to do all my own personal care is very important to me but this does not mean it comes easy trying to find where everything is in the bathroom if someone has put things back in the 'wrong' place. I can do all my own cooking having relearned how to be capable in the kitchen. Seeing me at work could give the impression that I do not need any help. I do not have enough confidence to go out down my road on my own because the pavements are so uneven. I have had a series of falls so rely on my husband to take me in the car to a safe environment such as a garden like Wisley, where I can walk with confidence because the paths have to be kept in good repair whereas the highways seem to leave all the potholes in place.</p> <p>7) One size does not fit all. It should not be a case of 'ticking' the boxes. How on earth can you compare a quadriplegic with a blind person or a deaf one. Instead of boxes maybe a description of the person's own capabilities would be a better way. Maybe certain tests relating to the personal disability should be considered. Those of us with a genuine disability would have no problem with seeing a proper medical assessor providing they understood all disabilities. Many visually impaired people appear to be able to see well because they have adapted so well to their condition. This should in no way reflect on their need for DLA. All disabled people should be commended and helped to achieve their full potential. Bearing in mind that as people get older these things will become difficult again and other impairments will probably affect them as well.</p> <p>8) All aids should be considered. As a visually impaired person married to a person with a reading difficulty, I contemplated for 2 years before finally buying a machine that would read correspondence. £1600. This is a lot of money but the DLA helped as I could save it up. Disabilities can often get worse as people get older.</p> <p>9) Many of the questions on the 2 parts of the form are the same. Condensing the form or maybe only having one benefit with varying levels would be simpler.</p> <p>10) I have a certificate registering me as severely sight impaired. This was the decision of my eye consultant who is best placed to know my disability levels. This should have been enough for me to qualify. If I have to go for a reassessment as is being suggested for all of us receiving DLA I would be quite horrified if the person doing the assessment simply held a card over my eye and expected me to 'read' a board. I would expect a proper eye examination with the relevant equipment which would give accurate results. You cannot falsify vision.</p> <p>11) I think face to face assessment would be fine and I would be happy for this to take place in my own home. However, it must be someone who understands the particular disability. You must send someone with knowledge of sight problems but not someone known to the applicant. Assessment in your own home could take into account how you cope with daily living and how aids if you use them help. This would take time but if it is to work properly and not be a case of 'Can you raise your hands above your head? Questions like this are pointless and meaningless to someone with a visual impairment and have nothing whatsoever to do with day to day living in my case. Assessing someone for DLA when they have only just had the life changing disability should also be taken into account. Adjusting to a new way of life varies for many people. If there is a level of disability that is a starting point that will save trying to assess people who only have slight problems which they can live with by being helped with medication or simple aids. Sometimes that is enough to help but others of us need more equipment.</p> <p>12) There are some occasions where a review is probably not needed. If there is never</p>

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	<p>going to be an improvement especially if you are totally blind or severely paralysed then reviews are probably unnecessary.</p> <p>Alternatively if you have the first assessment then you should be able to go back for the next review maybe after 3 years You should go back to where you had your first review or the review takes place in your own home and your original notes are brought along for comparison. When we see a consultant they have all our notes so this should be similar.</p> <p>13) This is difficult because many people once assessed are often discharged from seeing a consultant because their disability will not alter very much. Some of us need to see doctor's regularly. This is obviously the reason why a review system will have to be continued. Of course we could always have an MOT like cars with the results going straight to DWP and no form filling!</p> <p>?) As the majority of the talking gadgets I need are expensive I have to pay the bulk of the cost myself.</p> <p>One off payments for aids should be considered. Many people with varying degrees of disability use computers but adapting them for use can be quite expensive. Some things are now coming in as part of the system. Investment in assistive technology to bring prices down would be brilliant.</p> <p>?) Everyone should be treated as an individual and with complete privacy and dignity no matter what their age, gender, sexuality, colour ethnic background.</p> <p>No one should be left feeling as if it is their own fault that they have a problem</p> <p>?) I am concerned that you are simply trying to save money and will take it from wherever or whoever you can.</p> <p>DLA was provided to help with daily living. We should never be expected to pay for aids that without the disability we would not need.</p> <p>Removing components of DLA if someone goes into residential care is very unfair. Residential care is your home not your prison and you have every right to be able to go out as you like.</p> <p>This support however small gives back the chance to live life with dignity and as normal as possible.</p> <p>?) I find this question rather confusing. When confronted with a disability you need all the advice about coping with daily life The fact that you need help and advice as well as support from professionals and friends should be taken into consideration.</p> <p>?) I have not had a problem like this but there are people with dual or complicated disabilities They should only need one assessment even if it takes all day to complete.</p> <p>?) It has not been important in getting information.</p> <p>?) Regular checks and reviews of people's cases on a face to face basis should be enough. If their payments were stopped they would soon want to know why so could be called in for a review.</p> <p>People who are unable to understand the forms etc would have a case worker who would be responsible for their needs but it is doubtful that they would be the ones not notifying about changes.</p> <p>?) We would lose out and not know how to find information</p>
ONLINE258	<p>1) I lost my hearing ten years ago. It is an everyday struggle with communication. Work I get access to work for interpreter, but outside communication is very difficult and a simple thing like answering the phone you can't do it. crossing the road also as you can't hear traffic you have to be extra vigilant your confidence is also affected. going deaf is an invisible disability. At home boiling a kettle you have to watch it till it boils or you do not know. running a bath hearing you can hear the water deaf cannot so if you leave the taps running you are in danger of flooding. doorbells and tradesmen calling even if you stress to the company please TEXT only sods law they don't they phone your number and then you can answer it so they think you are not in. admittedly there are aids to solve a few of these problems but you cannot provide aids for human nature and education. The feeling of isolation because if you go to a party you cannot enjoy it because you have not got a clue what people are talking about. If you have hearing aids they are useless because of the background noise. The list is endless.</p> <p>2) allowing disabled people to spend the benefit in the way which best meets their individual needs.</p> <p>2) more bureaucracy more forms more assessments more waste of time for yourselves and other stakeholders involved in numerous claims</p> <p>3) If the benefit system is streamlined then if a person makes a claim for a benefit but has</p>

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	<p>already undertaken one assessment then information should be shared with the section dealing with that benefit. Only minimum additional information should be sought to assess eligibility</p> <p>3) This is an impossible question as it depends on the persons disability so cannot be answered. But I am happy that the scope of the benefit is to be widened as deafness is a big issue but does not necessarily always be treated fairly under the current legislation which assesses on personal care and mobility as in my previous response</p> <p>4) Although the mobility component is important I believe the benefit on daily activities should be equal to that of mobility particularly in the case of deaf people whose restrictions on a day to day basis would if not be worse than a persons mobility in their daily living so when assessed should have the flexibility to decide the payment judged on the persons disability and could award more payment for daily living and maybe less for mobility but again this needs to be assessed individually but should have flexibility there.</p> <p>5) As I have said in my previous reply it would be better to assess on individual basis. But once assessed should not be subject to further assessment if the disability is "life long" such as deafness you are not going to get your hearing back! I also think there should be a simple and quick assessment on life threatening disabilities to save the trauma of the individual.</p> <p>6) I agree with all of the above and am happy you are broadening the scope of assessment, however, I also think along with organisations you should enlist people who suffer the disability who know a lot more than organisations such as deafness. everyday needs are of course communication think to yourself what support you want to as you say plan a journey? answer the phone? ask for price of something in shop/ you maybe thinking ask them to write it down not as easy as it sounds deaf peoples first language is not english, please try being deaf yourself for one day.</p> <p>8) Again from a deaf perspective if you take into account aids this again must have the flexibility of their use for example when you are deaf you take your aids out at night or if you go swimming etc plus if you are in a crowded room or place with a lot of noise then aids are useless myself if you are close to me on a one to one situation with no background noise maybe able to understand you but if there is more than one person forget it. also it depends on your accent. so aids should not be a major factor in applying benefit.</p> <p>9) create a dvd with subtitles and a BSL interpreter as I have said earlier deaf peoples first language is not english. If necessary you should provide a BSL interpreter to go through the process with the individual</p> <p>10) In the case of deaf people it would be advisable for them to have a meeting first with their Audiologist not their GP as the GP once have hearing problem would pass over to audiologist who has seen the patient over a period of time and is responsible for their care. after the audiologist could submit a report to you. I appreciate you may wish to appoint your own but this would be restrictive as the person would not know the person on a day to day basis or long term also should take into account the individuals comments. I appreciate a minority would not be honest but the information supplied would be backed up by the professional involved with their care. As I have already said in terminal illness a simple assessment should be made that's it. Organisations can supply information but the person who suffers the disability is the one who can supply you with the most information themselves.</p> <p>11) I do not think this is necessary as the patient meets their health care professional then they would submit report to you if you need clarification on issues then you could contact the health professional yourself with the patients consent. This definitely would not be appropriate in critical illness</p> <p>12) the long term effects of the disability for example if someone has lost a leg then they are not going to get it back they may have false limbs but as with deafness if they take their leg off they will always have one leg! Obviously in the case of hard of hearing it would be assessed within the guidelines you set down. if the person is deaf then the review should be in negotiation with the Audiologist report and your guidelines so yes the assessment should be different dependant on the disability</p> <p>13) you need to have information in a format the claimant can understand such as I detailed earlier you need to have dvd with subtitles and availability of interpreter as requested or communication support for the claimant. if you arrange this the claimant can sign a declaration to this effect and if they do not agree to it then will be subject to the penalties above but only if you have made certain that the person understands this could also be signed by the interpreter if the claimant decides they want one or to say they</p>

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	<p>have understood the rules and regulations on the dvd. Having said that deaf people sometimes say they have understood when they have not so you need to be sure.</p> <p>14) offer to fund an interpreter for the claimant or communication support in order for them to claim this is question 14 now and i am lucky i was born hearing a majority of deaf people would not complete this form as it is too complicated how they can respond to you in BSL?they could watch the video but how would they respond ? english as i have said many times is not their language and unlike spoken language deaf people rely a lot on visual information so this needs to be accessible in appropriate format, this would help them to make a claim with the proper information.</p> <p>15) see previous questions. what needs to be avoided is inappropriate communication support this needs to be discussed with the individual. One of the most common things or misconceptions is that all deaf people lipread!! Deaf people's lip patterns are totally different from a hearing person so you cannot rely on having a full conversation relying on lipreading Try it yourself without a voice! Hard of hearing maybe able to understand some but it is a skill to be learned maybe get a professional lip speaker as i have said all along you need to have appropriate level of support in place and agreed by the claimant. you also need to meet the costs of this.</p> <p>16) there should be a one of payment for the purchase of aids not available by social services or NHS. and also a part of the benefit should be to upgrade the equipment or replace the equipment if it does not work. If the equipment is available on the NHS or social services you need to think about timescales if it is not possible to provide it in a reasonable timescale then an allowance should be given to purchase it. some people fund their aids through their DLA and take out loans to buy things and pay it back from their monthly allowance so a one of payment for the initial purchase would be an advantage.</p> <p>17) specialist advice from children's health professional and the comment their parents make in the child's day to day living and also from the child themselves</p> <p>?) I am really annoyed and disappointed that in your annex 1 deaf are not included in your table i think this says it all i have spent two hours on this questionnaire for you and all you have on your annex one is if you are deaf blind. maybe you have not included all of long term disabilities. but think if you are including deaf blind which i appreciate is dire deafness itself should be recognised as i have said all through this questionnaire and we are part of the Equality act as having a substantial disability which affects our every day life. I would be interested in what consultations you are having in relation to our disability, professional experts or organisations are not the best people to advise. many many government agencies promise to improve their knowledge on deafness and deaf awareness very few deliver if any come and spend a day with me.</p> <p>?) DLA obviously decreases the financial implications of the disability but all of the benefits and claim forms are in english and not available in appropriate format, and as you have stated yourself are far too complicated even the filling out of this questionnaire. deafness is an invisible disability and really is not taken as seriously as someone who has a visual disability so you need to make things as simple as possible and the claiming of allowances needs to be clear cut with no grey areas. If you are not sure of something you need to consult an independent person who suffers the disability not only take views from professionals or organisations.</p> <p>?) I am not sure what people you have as individuals giving you advice on deaf issues but all of my responses so far should be the subject of your impact assessment focusing on invisible disabilities as well as visible on the day to day pressures of every day life. please take into account all of my comments for this</p>
ONLINE259	<p>1) If they have physical disabilities or/and learning difficulties it is often impossible to use public transport. I have always been advised by professionals to avoid public transport for my son as it just proves to be difficult and stressful because of his behaviour and also his epilepsy and the difficulties that this brings.</p> <p>2) I cannot believe that you are going to take this benefit away from disabled children and their families that live in residential homes. This will mean we will lose the only method of transport we have to be able to visit my son and to take him anywhere. This has caused a huge amount of stress and distress to me on a personal level as I am on my own and I have a disability of my own so public transport is not an option for me with my son at all. I also have to collect carers so they can help me with my son as I can't manage him on my own. This is going to stop me from being able to see my son and him seeing me and his sister and other family members. This is catastrophic news for me and i am sure many</p>

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	<p>many others.</p> <p>3) Public transport is not an option so it would be taxi's which I could not afford and neither would they be practical for my son with his complex needs. The cost would be impossible to meet as I am a single mother. I am sure many other families will find it impossible to continue to see their children due to cost so this is going to have an impact on the families and also their child in care. I can't even talk to my son as he is non verbal and has a mental age of a baby so he will not understand when he no longer sees his mum because I can't get there as I have no transport and if I can get there. I can't take him anywhere so he can never come home so no quality time with his family. I cant expect people to do hundreds of miles just so we can spend time together and how much would that cost in a taxi.Let alone the cost of where we visit. Nightmare situation can't believe this is happening to the most vulnerable of our society.</p> <p>5) Dont feel able to answer this as don't have all information to hand</p> <p>6) By not taking away their transport so people and or families can take them places and be there to care for them. Life is hard enough when you have a child with disabilities so by taking this benefit away you have just made life impossible for families. How can this be answered as every situation is different and everyones needs and wants are different.</p> <p>I beleive the most important thing is to be with family to share things with family and friends and to also have time out from family to do things you enjoy outisde the family circle</p> <p>7) I dont know as I have a disability that changes hour to hour I don't have the answer to this.</p> <p>9) By being respectful as it's not something most people even want to have to do but needs must.Most would rather not have a disability</p> <p>11) Its ok if the health care professionals understands the condition and also don't come with any preconceived ideas of people being on benefits that they are all scroungers. I think it's not right for 1 person to have all the responsibility of saying a person can have a benefit or cannot have a benfit. I think interviews should be done where it is the least stressful for the client and is acceptable to the interviewer.</p> <p>12) I believe when a child has such complex needs that are obviously life long they shouldn't and their parents shouldn't have to go through the painful experience of talking about their childs disabilites as it is a very painful emotional process so if these could be given indefinatly that would be so much better for all concerned.</p> <p>? ) I think if people have conditions that are variable its hard for the sufferers to know when they will feel a bit better or how long that will last and if they say it's improved and then the following week they deteriate again it's hard to know what to do it's a very difficult situation to be in.</p> <p>I don't have the answer</p>
ONLINE260	<p>3) The extra cost of getting about itself, Fuel for the car, also heating I get no help with that either. We dont get anywhere near any extra financial help at all.</p> <p>5) That a hard one, I suffer from Psoriatic Arthritis, which will never go away, but in the warmer weather I can cope with it better, but the condition still remains as bad but slightly more barable, that does not mean it has got any better because I can assure you it has not. I can get about a little better, so if I am assest in the summer the result would give the assesser an untrue result, and I am sure this will apply to other people in a similar situation.</p> <p>7) I beleive that people with the same type of condition should be present at the time of the assesment of a single person, because you know how the condition feel etc so as to rule out anyone trying to fool the assesers. The assessers might have the medical knowledge, but only the person living every day with the condition knows how it feels.</p> <p>9) I was asked, How far can you walk without pain, so I put, quite a bit,,consiquently I was turned down 20 years ago!!, My Rhumatologist asked me why, so I told her, she promptly ask me the same question but first said to me, your feet hurt you all the time..yes I said.. so I ask you, how far can you walk without pain?? My answer now is, "Not at all". just because you can walk does not mean you are not in pain!! How many others has this happend to in the past and present??</p>
ONLINE261	<p>1) First I would like to point out that I think the idea of DLA being a barrier to work is wrong and I question the motives of whoever promoted that it might be. I do not think disabled people think of DLA as an out of work benefit. I have heard some media people get confused between DLA and Incapacity Benefit but I have never heard a disabled person</p>

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	<p>say they thought getting a job would take away their DLA.  Disabled people being cut off from support that helps keep them in work in order to save money is perhaps the biggest breach of equality.</p> <p>1) I have Primary Progressive Multiple Sclerosis. I am fairly independent given that my wife helps support me and my employers are very flexible. As fatigue is one of my biggest issues, no matter what model you use, I am unable to lead a full and active life. To some degree I have modified my expectations. I also have limited mobility. I would like to walk my dogs and have a plan to purchase a mobility scooter but with the reform hanging over me it would not be wise to buy one now when I may need to buy a car to replace my motability car should I lose this vital support. So right now the reform is one of the barriers. I think the idea that DLA is a barrier to work is ridiculous. It's what keeps me in work. Many of the barriers such as access to buses, trains and buildings are there in theory but the reality is different. For example, buses and trains lack reliability that you need when you have limited energy and a bladder problem. My own place of employment has disabled access but it involves such a long route to access it that it is actually easier for me to climb the stairs. We have a wheelchair using client who prefers to access the building by the goods lift rather than the official disabled access route. Yet if asked the company would be able to demonstrate that there is disabled access.</p> <p>In many places the disabled toilets double as baby changing rooms or are used for storage. My employer has the disabled toilets fitted with accessible showers that are also used by cyclists. They appear to be very disabled friendly but the reality is no toilet access when the room is in use. This is a major barrier for disabled people with bladder and bowel issues.</p> <p>My employer is actually quite good. They allow me to work from home. This is because the nature of my work allows me to do this. If I had to attend the office every day my fatigue would make me almost useless by the middle of the week. Therefore I assume for some this is barrier to work. With the social model there is no barrier. Fatigue a medical barrier.</p> <p>2) I agree that there should be an ongoing review. Up until now I have had indefinite DLA. I have left to get on with it. I like the idea of a review where useful advice or reassessment might ensure I always have the right level of support. However, it needs to be consistent. The current system is so haphazard that on asking for a review you don't know you are going to be wrongly assessed and lose DLA altogether and have to go through the appeal process to get it back. This uncertainty is difficult to live with. So the current concept of indefinite award is something I think should stay but with ongoing review too. This will not suit everyone but in the case of conditions where they know you are not going to get better it should be an option. Knowing you have support indefinitely allows you to plan for the future. I would not like to live with the situation I have now where I am always wondering what will happen at the next review.</p> <p>2) Without the passport function then every organisation that offered parking badges or other concessions that make disabled life easier would all need to have separate medical examinations or separate doctors enquiries. It is possible that one organisation might take a different view to others creating a disjointed, confusing and uneven situation. Having said that you should conclude that the PIP assessment should be the passport. As I said earlier perhaps a higher assessment is needed. Just because PIP involves money it is not what determines if I am disabled or not.</p> <p>3) Having mobility issues and needing to drive to work one of my biggest extra costs right now is fuel. I have a mobility car and so I insurance, tax and other costs covered for free but the rising cost of fuel eats through my income.</p> <p>having bladder issues I have ongoing costs of pads and cleaning/washing. I also have random costs of cleaning up after accidents.</p> <p>Being unable to engage in DIY and being unable to lift heavy things or reach high places I occasionally need to pay for the services of workmen, handymen or pay someone to do jobs for me. These are small jobs that most people of my age would do themselves.</p> <p>3) I think the existing NHS medical records could be combined with the PIP and other Disability assessments. This would seem to be a common point that all disabled people have and would be updated with the latest medical situation when it came to review.</p> <p>4) I have sent this idea in a separate email response earlier.</p> <p>I think there should be an additional rate that I call the nil-rate. This has no financial value but keeps disabled people in the review process. They are still disabled but just not eligible for financial support from the government. The nil-rate award would act as a passport for other non financial support such as Blue Badges and would also stop the claimant</p>

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	<p>appearing to have been a fraud who has been caught out and had their DLA removed. I think it is also likely that there will be people who are stuck on too low a payment on the lower rate as they are not totally incapable and eligible for the higher rate. I wonder if the idea of fixed rates is really too inflexible. Perhaps it should be ranges of payments. For example, in work I am on a pay grade with my colleges. We do not all earn the same but we are all on the same grade range. The better of us earn the top end. However we all earn less than the managers on the next grade up. Perhaps the rates of care could be variable within the lower and variable in the higher with the decision maker deciding the right amount based on individual circumstances.</p> <p>5) I think where the condition is known to only get worse and will never get better then it would be better for everyone if entitlement was automatic. However this does not mean the person would be outside of the review process.</p> <p>6) I think there is a danger that if you prioritise on the "least able" then there will be a lot of more able disabled people who will struggle and for the want of a little support will become less able and more of a burden on the state. I am working full time with a little help and pay far more in tax than the value of my DLA. If you prioritise on the least able I will struggle. I don't think its a question of prioritising but of balancing.</p> <p>7) This has been a much discussed issue on the disabled online forums. People are often advised to describe their worst day. This is difficult as it sounds like they are being told to be less than honest. I am fortunate in that my Primary Progressive MS is constant and does not fluctuate at all but many people with Relapsing Remitting MS have variable symptoms. I think the effect on peoples lives with these variable symptoms can be worse than it is for me as people (e.g. employers) can see my disability every time we meet. They may not understand someone who is disabled only sometimes. I suppose the best way to assess is to look at the medical history and discuss it with the individual.</p> <p>8) I walk slowly with a stick. I might be advised that with a wheelchair I would move faster but I feel that I would lose what little ability I have. I prefer to struggle with walking. If the assessment decided that I am less disabled (social model) if I used a wheelchair then am I going to labelled as someone who refused help? Without my stick I am far more disabled. I would fall over for a start. I would not expect to be assessed as unable to walk at all for the want of a stick. However the stick does not mean I am able to walk normally. I think its an intelligent decision that should be applied to individual cases. I think it is ridiculous to suppose that a wheelchair user, under the social model, is not disabled because he can move freely at walking speed and can, in theory, get on a bus or train.</p> <p>9) Stop using expressions like "the greatest need", "the least able", etc. I have no idea if I am disabled enough and I suffer pain walking short distances. Everyone tells me of course I will not be affected by this reform but I hear ministers talking about PIP being for "those with the greatest need" and I know of people who are more disabled than me. It really isn't clear. I wrote to my MP. He said those who are genuinely disabled have nothing to fear. If the new social model redefines disability then I dont know if I have anything to fear or not.</p> <p>10) I think evidence from the claimants healthcare professional but also the assesement needs to be open to whatever evidence is presented and its relevance considered. Given the range of disabilities being included the assessment needs to be flexible.</p> <p>12) I do not think it is reasonable to expect the claimant to report changes in their needs. In my own case I am hardly aware of the progression of my disability over years. It is other people who see me less frequently who point out that I am walking less well than last time they saw me. I think the best approach is to have a fixed review. However, this should not be like the current system where the review is like a fresh assessment as if its the first claim. Records would need to be kept, maybe as part of the medical records rather than a costly new record system given that the doctor is going to involved in the review. The healthcare professional could also be involved in maintaining/updating the record between reviews too.</p> <p>Perhaps the frequency of the reviews would be less and less frequent, depending on the frequency of change, unless requested by the healthcare professional or the claimant.</p> <p>14) Yes I think the assessment and the review is a good time to provide advice and information. This might be done in such a way as to make the whole meeting a more positive event. It would need to be done by someone with expert knowledge. It must not be "token" advice or pointing out what to a disabled person is obvious. Taking the advice must not be conditional for contining to recieve the support. For example I choose not to use a wheelchair. I might be advised to but I think I am fitter struggling on without one. The wheelchair will come eventually but I would not want to be forced into it as a condition of</p>

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	<p>receiving PIP.</p> <p>15) I am against this whole idea. Advice should be offered and discussed. But not a requirement. You would not make 'not smoking' a requirement of receiving NHS treatment. I am actually all for providing advice and support but who are these experts on me who can override my own knowledge of my best interest. I think the idea of "do as I suggest or lose your right to support" is possibly against Human Rights law.</p> <p>16) I use my mobility component to provide a reliable car. I use the care component to provide consumable items such as incontinence pads. I pay for my own walking sticks. The NHS pay for my foot supports. I am planning to buy my own mobility scooter one day. I think to keep things simple the PIP should be a regular payment for ongoing costs and other grants, such as Access to Work, should be available for one off items.</p> <p>17) This question is intentionally left blank. This is outside of my area of knowledge.</p> <p>?) I think not enough has been said about the appeal process. If there is to be an ongoing review will there be opportunities to appeal at every review if the claimant disagrees with the assessment?</p> <p>If advice or support offered were made a "requirement" would that be something the claimant could appeal against.</p> <p>?) I think the Governments desire to save money will distort the passporting function of DLA. Perhaps there should be a higher assessment that determines if someone has disability issues. This would be the passport to Blue Badges and the city of London's Red Badges and various other support services. This could also be the passport into the PIP assessment process. The claimant might be refused any PIP on the criteria used to save money except for "those with the greatest need" but as they have already been identified as disabled they would still be passported to support from other non financial support services that maybe makes the difference between being able to continue working or living on benefits.</p>
ONLINE262	<p>1) Still not enough level access in shops + isles are stocked with boxes etc blocking wheelchair's from turning. Still no thought given to what disabled really need, car parking for disabled is not enforced either in retail parks or supermarkets should be illegal as in U.S.A Hospital visits are nightmare with parking.</p> <p>2) The ability to use the allowance as we see fit to help enrich our daily living</p> <p>3) Apart from the usual extra costs it has become more and more obvious that using mobility component for a W.A.V vehicle that the increase in diesel + vat has made my freedom to independence very shallow as I now have to think what will my journey cost + can I afford to go out or save it for only important trips. this gets away from the whole concept of independence. I believe Ireland have scheme that allows vat exemption on diesel for those on DLA. Private purchase of disability aids is a must as NHS never gives a level of aids that equals a real need. Prescriptions dentist opticians do not assume everybody claims benefits that make them exempt. Maintenance + repairs for aid purchase's ie: batteries covers armrests, tyres + cleaning. Heating extra clothing + wet/cold weather aids for wheelchair users</p> <p>8) Should a cup be accessed as an aid to drink a cup of tea? Aids + Adaptions are in place to elevate problems "normal" people don't have that does not take away the fact that there is a disability and a need for help. don't assume an aid removes a problem and makes a person on a par with "normal" people.</p> <p>11) My experience of healthcare professional's is they tend to tell you what you need as they are the professional they know best, while suggestions from them are good I find they still tend to impose their ideas as what's best on you. Never again will things be done "about us without us"</p>
ONLINE263	<p>1) The major barrier preventing disabled people participating in society and leading independent, full and active lives is lack of income. Although some disabled people do manage to work, they are almost always limited in the type of work they can do by their disability thus, their earning capacity is also limited, usually in a very big way. Even those, like myself, who manage to do some paid work are seldom able to continue working until normal retirement age and their earnings limitations means they are unable to save for a pension. The other major barrier is in being able to get around independently in a society where daily living evolves around the use of a car and where public transport is extremely</p>

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	<p>limited in many areas, if it exists at all.</p> <p>As a blind person I feel more and more isolated from society due to my inability to get around on my own and the difficulty I have in assessing modern technology which is taken for granted by most people.</p> <p>2) The above points are all a vital part of the benefit and I hope the promise will be kept to keep the new benefit non taxable and non meanstested. It should certainly never be meanstested for for anyone who has paid National Insurance or whose spouse has paid NI.</p> <p>I am very concerned that it may not continue for people after the age of 65. This was an important part of DLA in that it recognised that a disabled person, through no fault of their own, had severe limitations with regard to job prospects and earning capability, and therefore their ability to save for retirement. Although I managed to work for several years with my disability, I was unable to do the kind of job I would otherwise have done and as my health worsened I had to retire early just at the time of life, as my children became independent, when I would have been saving hard for my retirement. The only consolation I had was that I would receive DLA after 65 and I am just terrified at the thought that it might be taken away from me when I needed it more than ever.</p> <p>I also feel that a lot of money is going to be spent on unnecessary reassessments. Surely the people who know best the problems the recipient has are his carers and doctors. Certain conditions that are permanent or even degenerative, should be exempt from continual reassments which would cause added stress. There may be some disabilities that might improve or be treated successfully but even then consideration should be given to the fact that the person's earning capacity would have been severely restricted during the time they were disabled.</p> <p>3) The extra costs faced are many and various and will differ with each disabled person. However, what is universal is that disabled people face the same costs as other people for everyday survival and their ability to earn money to cover these costs is hugely restricted by their disability. I would guess that the majority of people receiving DLA have to use it replace the loss of earnings due to their disability. The new proposals seem to completely ignore the fact that disabled people have the same needs as others, eg housing, food, heating, etc but do not have the opportunity to work to pay for these. It is easy to say that it is easier to find work in modern day but this is simply not true. Why should an employer take on someone who is going to need more help, probably have more time off and not be able to achieve the same as a fully abled person? Even if a job can be found, there is the problem of accessing the workplace and the huge cost of taxis where public transport it unavailable.</p> <p>In terms of extra costs for daily living these can include wheelchairs, all sorts of physical aids, special software for computers, special vision aids such as cctv and digital magnifiers (all of which are extremely expensive) extra heating and lighting, special diets, taxis, and most of all, care and assistance from other people. Anyone with a serious disability will be dependent on other people for most of the things that other people take for granted.</p> <p>4) I think that the existing rating system is easy to understand and takes into account people's change in needs as their disability worsens or changes. Three rates of care is correct as there is a huge variation in people's needs and it is very important to take into account a person's need to be supervised to prevent accidents and injury. A person may physically be able to walk but may not be able to do so safely, either for them or people around them.</p> <p>The current system of rating for needing care in the daytime and/or at night seems very relevant to me as disability is with you 24/7 but not everyone will need nighttime supervision or help.</p> <p>5) In order to save wasted costs of assessing people with permanent and recognisable disabilities I believe that certain conditions, including the ones listed in Annex 1, should have automatic entitlement. It will not be an easy task to assess other health problems and efforts should be concentrated on doing these assessments properly. There will no doubt also be many appeals which will cost further time and money to the system.</p> <p>Someone who has lost a limb or their sight or hearing will always be disabled no matter how many artificial limbs or hearing aids they have. They may be able to do some things but it will always be difficult for them and they will always have barriers. There is no way of giving someone artificial sight and therefore I believe blindness should also give automatic entitlement. A guide dog or a white cane are no replacement for eyesight. If you disagree just try spending a day with a blindfold!</p>

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	<p>6) There are obvious ones including getting washed and dressed, keeping clothes clean, cooking, keeping home clean (which is not part of current assessment but is as important as keeping oneself clean. I don't see how they can be separated), keeping safe in the home (ie avoiding falls and other accidents and injury), keeping safe outside the home, crossing the road, getting about generally, being able to get to shops, doctors, hospital, dentist, library, bank, etc., being able to read and respond to correspondence, being able to use the internet is fast becoming an essential part of everyday life (which is largely being forced upon us), being able to read books and watch or hear TV and radio, having social contacts and being able to go out to meet friends and family, being able to work and to get to work, visiting cinema and theatre, museums, galleries, cafes and restaurants, etc, and to attend courses and classes, have interests and hobbies, participate in sports and take exercise even if only walking or swimming in order to maintain the best health possible in spite of disability.</p> <p>7) I appreciate that this can be difficult in some cases but the carer and doctor would be the best people to assess these cases rather than someone who does not know the person or their history. I feel these are some of the people who will suffer most under the new system. The whole reason for changing the system is to save money and the aim is to reduce the number of claimants. I stress again that I can see just as much money being spent, possibly more, except that the money will be going to agencies and assessors and on administration instead of to the disabled people who need and deserve it. Will we ever be told these figures and given an analysis of expenditure and how much and where the money is going? I guess not!</p> <p>8) I do not believe that a disabled person should be penalised because they are able to use an aid of any kind. By definition anyone who needs to use wheelchair, crutches, artificial limb, guide dog, hearing aids, CCTV, digital magnifier, or any type of aid not required by a non disabled person, is 'Disabled' and therefore requires the support supplied currently by DLA and, hopefully, by PIPs. It sounds as though someone with a prosthetic limb will no longer be considered disabled! This is outrageous and unbelievable.</p> <p>9) I personally think that the current information on DLA is perfectly clear about its aims and who is eligible. I really do not understand why it is being changed except that it is 'change for change sake'. At the end of the process I do not believe any money will have been saved but I do believe that many disabled people will suffer hugely. The forms are difficult to fill in for some people because they expect the claimant to have exactly the same problems every day and the same number of times a day. Disability does not always work like that as the problems faced are so numerous and variable. The forms do not take into account the variation that some people have in their condition.</p> <p>10) I believe that the GP and hospital consultant or other healthcare professional who knows the person and their problems are the best people to make the assessment in conjunction with the carer and the claimant. It should be understood that the vast majority of disabled people can only cope with their disability by being as positive as possible and by concentrating on what they can do, however little, rather than what they cannot do.</p> <p>11) This would be appropriate providing it is done on a fair basis and the claimant is not put at an unfair disadvantage. The claimant should be given sufficient information about what the meeting will involve and what questions will be asked so that they can give proper considered answers. They will be under considerable stress as the outcome could be devastating for them.</p> <p>12) The type of disability should be the criteria for frequency or reviews. Many people have disabilities which are permanent and which can only become more difficult with age. Such conditions should not need to be reviewed as this would be a waste of resources. For other disabilities the frequency of reviews would have to be decided on an individual basis but always with careful consideration. A non disabled person cannot possibly understand the importance of this benefit.</p> <p>13) If a person is knowingly receiving the benefit when they are not entitled then this is fraud and should be treated as any benefit fraud but there is often a fine line between being eligible and not and cases should only be pursued when there is definite evidence of fraud.</p> <p>14) The person's health professional would be the one to provide this information and advice and is probably already doing so. They would know the person's needs and also the local agencies who could offer help. Such help and support differs enormously on a regional basis and is likely to be greatly reduced as a result of government cuts by the time</p>

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	<p>the new benefit is rolled out. A lot of money could be wasted here with too many people trying to do the same job with very little actual result for the disabled person.</p> <p>15) So often disabled people are sent on a wild goose chase with offers of support that just do not materialise due to lack of co-ordination, lack of funds or staff, or just simply because the actual individual needs of the disabled person are not fully understood. The problem is that most people genuinely want to provide advice and support but, at the end of the day, it is just not available and the disabled person is left to research their own supply of aids or support. Money is therefore wasted on good intentions when it would be better given directly to the disabled person who knows their needs better than anyone. I am blind and also have ME, fibromyalgia and an auto-immune disease which flares up occasionally with very serious effects on my health. As a result of one flare up I have lost all balance function in both my ears leaving me with serious mobility problems. This combination of permanent disabilities is very rare and very well intentioned people sent me to various experts in the hope of getting help for me. In the end, I got a huge amount of sympathy but no actual help and I was left to make my own walking aids by adapting ordinary hiking poles with my husband's help. There must be many other disabled people out there with an equally difficult combination of problems.</p>
ONLINE264	<p>1) The inability to access services due to lack of finance i.e. day care, social groups. Unable to work because of not being able to afford specialized transport to and from work.</p>
ONLINE265	<p>?) I am particularly concerned about the impact of these changes on people that spend their adult life in registered care homes. It has been proposed that the mobility component is removed from people that live in registered care homes. Significant numbers of young disabled adults still choose to live in residential care homes. Although their care needs are met within that setting, they retain both the need and the right to participate in community life and use the facilities enjoyed by all other citizens.</p> <p>Their mobility needs are not reduced by living in registered care settings, and the fee levels agreed by local authority funders of registered care seldom include contributions to the mobility costs of this group of people. They generally assume that people will fund the specific costs associated with their mobility needs through the mobility component of their DLA.</p> <p>The government should ensure that the new benefit arrangements do not discriminate against those young disabled adults whose support is best met within a residential care service.</p> <p>Loss of this element of their benefit would dramatically impair people's ability to participate in any community life outside the walls of their residential home. People the Brandon Trust supports have lifelong disabilities, and their need for additional mobility support may also be lifelong. Loss of mobility funding would in effect bar them from all access to community life.</p> <p>?) The following case study illustrates the potential impact if young disabled adults that choose to live in a registered care home are excluded from the new benefit. The five people have behaviour associated with their learning disabilities that can be challenging. Listed below are the amounts of weekly Mobility allowance that each individual receives</p> <p>M, N, V and A all receive £49.85 E receives £18.95</p> <p>Their current entitlement to DLA with the mobility component allows them</p> <ul style="list-style-type: none"> <li>· to meet the cost of hiring and running a vehicle</li> <li>· Free access to a vehicle at all times especially in the event of an emergency</li> <li>· The choice to go out as and when required</li> <li>· Less stressful and higher level of safety than use of public transport, if that were readily available</li> </ul> <p>It is felt by the staff team as a whole that if this benefit was removed it would have a large impact on the individual's community access especially those that depend on having their own vehicle to access rather than having to rely on public transport and having the funds to enable them to do this.</p> <p>Due to individual risk assessments they have specific adaptation needs which could not be met by the use of public transport. They have specific seats to sit in and safety harnesses that safeguard them and the driver from injury at the same time reducing risk to other road users.</p> <p>Due to individuals high support needs it is necessary that they have ready access to their own vehicles, especially when out, which allows them to return to the safety and comfort of</p>

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	<p>their own home when they need to rather than having to rely on public transport  It is also felt that the men s difficult behaviours could increase due to having to use public transport. Some individuals have risk assessments in place that indicate the individual can not use public transport safely.  In the absence of funds to support people's individual mobility needs we would expect to see more challenges within the home, increased agitation, reduced quality of life for all residents, impaired mental health possibly leading to increased need fro mental health interventions. Staff sickness may increase due to an increase in the mens challenging behaviours causing a greater strain on the service provided and the Organisation.</p>
ONLINE266	<p>1) I am answering this from my personal experience of my partner who has ME, anxiety and psychosis.</p> <ol style="list-style-type: none"> <li>1. The cost of healthy food that requires little preparation (as my partner is too ill to cook, and healthy meals make a huge difference to her health</li> <li>2. Transport costs (such as the high cost of taxi). Public transport is not always usable due to anxiety, the inability to stand etc.</li> <li>3. The cost of clothes as her medication means that she changes weight all the time so needs three wardrobes than one</li> <li>4. The cost of heating in the winter as she is at home (rather than at work) and feels much more ill unless the heating is very high.</li> <li>5. Stigma from being on benefits and for having mental health issues. This is a huge issue that results in her having poorer mental health and low confidence. The stigma is widespread and very hurtful.</li> <li>6. Problems with services not bring open at times when she is well enough to use them. This includes GPs, community mental health teams but also shops etc.</li> <li>7. Lack of day time facilities such as classes and day centres means that she does not meet other people is a massive problem and makes her health a great deal work.</li> <li>8. Not having any social care means that she is often unable to look after herself when I am at work. Taking time off as led to me having slower promotion and has added to our financial difficulties. Examples of this are not being able to get out of bed, get a drink, get a shower or get dressed.</li> <li>9. The fact I have to work means she gets insufficient care.</li> <li>10. The cost of activities such as sewing and knitting that build her self confidence and we hope can be a first step towards moving towards work (as long as the disabilities decline).</li> <li>11. The lack of support for people with ME (there is very little available).</li> <li>12. Not being able to get out of the house due to anxiety.</li> <li>13. Not being able to walk long distances. Not being able to walk at all when there is snow for example.</li> <li>14. Not being able to exercise due to ill health - that would help her get better.</li> <li>15. The problems in applying for benefits which makes her health worse. The current system means that people who need support are not getting it so it needs to be made easier to get. One problem is that people naturally under-report their problems as they are trying to be positive to help their own health. My partner should have been on DLA years before but failed as she had under reported problems. Any changes to the system must take account of the applicants ability to get through a process, under reporting and the stigma caused by the process.</li> <li>16. The stigma of being overweight due to medication.</li> <li>17. The fear of crime, violence, and anti-social behaviour.</li> <li>18. Even very low level antisocial behaviour such as pushing in a bus queue make her extremely nervous.</li> <li>19. Inability to meet new people or go to new places alone.</li> <li>20. Most people with anxiety for example would struggle to fill out this form which means that the consultation will be biased.</li> </ol> <p>3) I am answering from the personal point of view of my partner who as ME, anxiety and psychosis. There are considerable costs to disabilities that are not being reached by DLA. The costs are likely to increase as services are being cut.</p> <ol style="list-style-type: none"> <li>1. Transport (ie public transport when she cannot walk)and taxis when she is unable to use public transport due to anxiety and having to stand up. Public transport in London is nearly always crowded and this makes it impossible for her to use it a lot of the time. There is no direct cost to some of the transport problems in the sense that she is simply unable to leave the house which further increases her ill health.</li> <li>2. Shopping. Firstly getting things on line is necessary so that adds to postal shopping.</li> </ol>

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	<p>Supermarket shopping is more expensive as there is not option to buy in bulk due to the weight. In fact I do all the shopping as any shopping is hard for my partner.</p> <p>3. Food - the cost is higher as we need to use ready meals - partly because my partner is too ill to cook, partly because I work long hours to make up the lack of money of her not working and that means I do not have time to cook.</p> <p>4. Cleaning. We are not always able to manage this - this is not a cost in the sense that we just live in a mess but it would be a cost if we could afford it to be.</p> <p>5. Social care costs. Again we do not have the money or state support but we should have social care support to help my partner getting dressed in the morning etc.</p> <p>6. Heating - as she is ill at home all the time our heating bills are much higher than they would be. Also they are higher as she needs higher heat to stop her getting ill with the ME. If it is cold or even normal temperature she is much more ill.</p> <p>7. Food - unhealthy food - which is often cheaper and more easily available has massive problems for her health and weight. The medication also means that certain foods make her sick so there are additional costs there.</p> <p>8. Hobbies. These are vital for her wellbeing, long term health and attempts to eventually get into work. Although her hobbies are not expensive knitting, sewing etc still cost a lot of money. At the moment reading is cheap as we have a local library but this could well close.</p> <p>9. A day care centre would massively help with point 8 and could help her into work but it is not available.</p> <p>10. Classes. As there are no available local courses we paid for some evening classes for her to help with her recovery and standard of life. However we had to stop this due to the high costs.</p> <p>11. Exercise can also be expensive particularly in areas where walking is not possible. It is also a vital part of getting better for those who are able to do so (often to a limited extent. Walking is harder in areas where there is high crime and antisocial behaviour and disabled people face a lot of stigma and abuse - and get worried about people's thoughts about them - particularly due to the recent government policies and statements about them.</p> <p>5) It makes sense for people with some conditions to have automatic entitlements as it is likely to save administrative costs. Also applying for benefits is extremely difficult and has a massive impact on people's health. Making people apply for things they will certainly be eligible for makes no sense at all. Of course this should not stop people applying for additional needs if they have them.</p> <p>7) 1. The complexity of this means that private companies such as ATOS should not be involved in the process as they have failed completely with IB. Instead charities and professionals who understand the conditions should be involved. For example, a specialist in mental health should have to assess benefits for that.</p> <p>2. The forms need to be more flexible and allow more room for personal statements rather than yes/ no style questions that do not reflect the reality. From a practical point of view open questions should be placed before closed questions so that the yes/ no answer is based on more thought and deliberation.</p> <p>3. There should be funding for charities who support people's applications as it is pretty much impossible for somebody with a disability to fill out the form accurately.</p> <p>4. Efforts need to be made to ensure that people are not under representing their conditions. People often do because admitting the extent of their problems is really depressing.</p> <p>5. Forms should clearly state whether they are asking people to write a response based on a good day, a poor day etc.</p> <p>6. It is unfair for re-assessment to be based on how somebody feels at a particularly good period of their health. If people report improvements there should be an option for them to report things getting worse again without having to start the whole process again.</p> <p>7. It must be remembered that people do not like being on benefits and will try to stay off them if they possibly can. The problem is to few people receiving DLA not too many.</p> <p>10) 1. A wide variety of people would be well placed to provide statements based on the different circumstances people have.</p> <p>2. Carers are very well placed but will need support in providing evidence. They are often the only people who not what is really going on. However expressing this is difficult as they are not medical experts and may not know what normal is.</p> <p>3. GPs are well placed if they have known the person for a long period of time and see them frequently. However this does not always happen. It is important to remember that people are very deferential to GPs and other health specialists and often pretend they are</p>

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	<p>coping better than they actually are. People do not want to suffer the stigma of being considered unable to look after themselves even if that is the case.</p> <p>3. Charities and support groups would be helpful where they are available as they have a good understanding of the person and the system.</p> <p>4. Other health specialists depending in the condition would be helpful.</p> <p>13) If you want people to report changes there has to be a system whereby they do not lose all their benefits based on what might work out to be a temporary improvement. People want to get better but are scared (probably quite rationally) that by reporting a small change they are likely to lose their benefits or be reassessed the stress of each could make them worse off in the longer term.</p> <p>Also people are less likely to report things getting worse - until they result in major health or related financial problems as the illness will make them less able to report changes. For that reason health professionals etc should support people by encouraging them to report things getting worse.</p> <p>I am afraid I am very sceptical about the system being easier to understand. If it is made easier to understand it will probably be less able to offer the flexibility needed. It is already not flexible enough.</p>
ONLINE267	<p>1) One of the barriers to accessing the community can be mobility not necessarily physically, but the ability to use public transport; understand road safety; and being able to ask for help. The other problem areas can be in the persons ability to care for themselves whether it be personal hygiene; keeping healthy; cooking and eating; or caring for their homes. Unless people get the correct level of support they will be at risk.</p> <p>2) It will be important that if people are reassessed and their needs HAVE NOT changed they should not have a reduction in the amount of the DLA they will continue to receive.</p> <p>3) To travel in the community many people are required to pay for taxis as they are unable to use public transport. They may also have to pay for services such as chiropodists, counsellors, day services, college courses.</p> <p>5) As a carer for young people with learning difficulties they should have an automatic entitlement as this is normally a lifelong condition which is unlikely to improve significantly but their condition may deteriorate at which point there should be a reassessment.</p> <p>6) Unfortunately an assessment of needs will be required initially.</p> <p>Essential activities:  To be able to access the community  To have daytime activities such as work, college, voluntary work, day centres  To have opportunities to access leisure activities</p> <p>10) People with learning difficulties are regularly assessed by their social workers it would seem logical to use this information.</p> <p>11) Why is it necessary to assess people with learning difficulties and disabilities again when they are regularly assessed by their social workers. Also the healthcare professionals used as part of the new process will need to be experienced in a wide range of areas such as physical health, mental health, learning difficulties and disabilities otherwise they might not have a clear understanding of the issues.</p> <p>12) Any changes in circumstances, health or disabilities should bring about a review. The reviews need to be tailored to the persons impairment or condition</p> <p>13) Any alterations in circumstances are often noted by other professionals such as social workers, doctors or healthcare officials would it not be possible for them to pass this information on to the Department</p> <p>? Additional assessments - more paperwork - more staff more costs !</p> <p>? As children are normally part of a family would it be appropriate to make this a means tested benefit ?</p> <p>? It is important and useful to be able to link the entitlement to DLA to other benefits as I hope it means that the need to carry out further assessments are not necessary - less paperwork - less bureaucracy - saving government money</p> <p>? Linking up with social care and health assessors - housing benefit teams - job centres</p>
ONLINE268	<p>1) The main barriers are social and environmental. Negative attitudes (seeing disabled people in a deficit way), inflexible communication methods, inaccessible transport - all leading to exclusion.</p> <p>2) People currently in receipt of the higher rate mobility component of the DLA should continue to receive this allowance if they are in residential care or need to go into</p>

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	<p>residential care. It is a nonsense to say the allowance duplicates money already allocated by local authorities to care homes to fund transport. Removing the allowance for people in care homes will mean thousands of disabled people will be institutionalised and contradict the whole concept of personal independence.</p> <p>?) I do not have sufficient knowledge to list benefits which could be combined but endorse any move to minimise bureaucracy and duplication.</p> <p>3) Obviously this varies. Undoubtedly the major cost for a high proportion of disabled people is linked to getting about i.e. access to normal daily life whether this is in the home or from home to work, church, visiting friends and family, going on holiday, the doctor, shopping etc</p> <p>4) The 2 rates seems reasonable and will be easier to administer. The difficulty will be that there will inevitably be a wide range of need within each category.</p> <p>5) I think that any proposal that pours more time, effort and money into individual assessments and re-assessments is counter to the aim of giving front-line support to disabled people and to the governments need for spending cuts. It smacks of a culture of 'the deserving' and the 'undeserving'.</p> <p>6) Ask what an individual's aspirations are. The activities /needs most essential for everyday life (see Maslow) will vary once we get beyond basic physical needs. Some people may need a high level of personal daily care yet be skilled drivers of an adapted vehicle. The vehicle may give them the freedom to work and socialise etc.</p> <p>8) I think any assessment should be based genuinely on the social model. The question should be 'What barriers/obstacles does a particular disabled person face?' Then, 'What do they need by way of assistance or aids (eg prosthetic limb, wheelchair, personal assistance, adapted car) to minimise the barriers?'. Then 'What is the extra cost to the disabled person of acquiring what he/she needs?'</p> <p>This has implications for who assesses. It needs to be people who thoroughly understand the social model concept and should NOT be a medical approach.</p> <p>9) Suggest questions that reflect the social model. Eg. In order to manage the following activities as independently as possible what sort of assistance, if any, do you need ..... Give examples, e.g. personal help, an electric wheelchair or scooter, a prosthetic limb, screen magnifier etc. ..... getting washed and dressed .....preparing a meal .....doing your shopping .....getting to work</p> <p>10) I believe this proposal belies the government's alleged commitment to a social model approach. It is an unnecessary, expensive, time-wasting and insulting. I believe that the medical assessors that are selected for these kind of roles do not have the skills for the job. It will be a HUGE waste if everyone is re-assessed. The Govt. should convene a group of high profile disabled people to lead on any root and branch reform to the DLA. The objective of the exercise SHOULD NOT BE COST-CUTTING.</p> <p>12) This is a potentially cumbersome and inefficient use of valued resources. Possibly some straightforward trigger to alert individuals to reporting any significant change to the obstacles they are facing. I think the view that the successful use of aids such as wheelchairs may be interpreted as the person having unrestricted mobility is ridiculous.</p> <p>13) I think the overwhelming majority of disabled people receiving this benefit will have permanent and increasing needs. I believe that the Department is over-concerned about people claiming falsely.</p> <p>14) Don't overload. Give a few key links to helpful national Disability Organisations e.g. RADAR, Mobilise, etc</p> <p>15) Difficult to understand this question! If you mean people should be compelled to seek advice and support then 'No'. - not as part of awarding this benefit.</p> <p>16) Speaking for myself I either fund any one off payments e.g purchase of an electric scooter, from my work income or through the Motability Scheme (payment of car adaptations) It would be helpful to be able to meet one off costs through the PIP</p> <p>17) Try to avoid multiple assessments from different agencies which duplicate information and frustrate and exhaust all concerned.</p> <p>?) Access to motoring entitlements has been very beneficial</p>

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	<p>?) More paperwork, applications, time and effort.</p> <p>?) The proposals are likely to have the greatest negative impact on older people and more severely disabled if the mobility component is withdrawn from people living in care homes. This will also have a knock on effect to people in care homes who are not white or heterosexual as they will be unable to use their independent means of transport to access the world outside and pursue their social and religious networks.</p>
ONLINE269	<p>1) Ignorance and lack of understanding is at the heart of the public sector who have been trained let alone those that haven't been educated on disabilities. For those severely effected it is the lack of a responsible suitable person to take you out and supervise or help. A 20 year old young man does not want a 50 year old woman to go out with. Very difficult to get suitable living accomodation that is supported but still near family. Integration into a persons community should be started long before they leave school. Disabled children should be STOPPED being taken out in large groups that look like a circus. Disabilities should be everywhere and not just in clusters.</p> <p>2) The mobility scheme.</p> <p>3) Buying in help. Carers not being able to work so income into the house hold is poor and then lifestyles are impacted on. Travelling to special groups, accessing help that has specialism. Therapies. Always needing support and having to pay.</p> <p>5) Can't trnink of any disability that affects everyone exactly same so individual is good. Severe Mental impairment is one that would mean all require a high level of support but even then it's variable person to person.</p> <p>6) Having a normal life outside your home. Being able to be part of society and member of your community and having friends is important to maintain good mental and emotional strength. To have a reason to get out of bed in the morning and be someone. Regardless of the problems even a very minimal opportunity to work and have worth is vital. Keep those that help find jobs for disabled people, put in support for finding jobs but ENSURE that those supporting know what they are doing.....</p> <p>8) Yes. If an adaptation gives you any more independence then that should be included. There are many that regardless of an adaptation still need a huge amount of help and they are the ones struggling.</p> <p>?) Once you have been assessed a card saying what level of award you recieve would verify your level of need for other services</p> <p>?) Please ensure that those who assess are not being paid to limit or increase numbers, and they must have a wide knowledge of disability visual and hidden. Do not let assesements be done by anyone that is not qualified to assess in that area.</p>
ONLINE270	<p>1) physical barriers - poor access, poor provision of information in different formats, poorly maintained roads and pavements, poor lighting in public areas.</p> <p>social barriers - Lack of understanding in front line staff who deal with the public. stigma. Lack of understanign of variability of health conditions(especially mentla health conditions) - this barrier relates to claimants of DLA and the assessment procedure.</p> <p>Vocational barriers - lack of clear usable pathways for disabled people who want to move off benefits and into employment. Complex benefit and welfare arrangements which place disabled prople at risk of financial hardship.</p> <p>Financial barriers - high cost of non standard aids / adaptations to support independance.</p> <p>2) DLA should remain non means tested.</p> <p>DLA for peoploe in or seeking employment should be clearly linked to such provisions as Access to Work. The link is not always clear to claimants who could also consider different types of employment if they were aware of the support provided by this provision and how to access it.</p> <p>The mobilty component should reflect the actual mobility support needs of the claimant in terms of their individual mobility needs (someone with a full time job and associated transpost costs will have different requirements from somoen who does not, the availability and accessibility of useful public transport should be considered)</p> <p>3) travel and mobility costs</p> <p>costs of assistive equipment that is not freely available through the NHS / Local Authority care costs - a vast majority of care is provided by relatives / friends who are not paid by the individua. This is care on the cheap usually because the individual does not have sufficient income to pay an appropriate rate for this care.</p> <p>communication costs - telephone / mobile telephone / internet</p> <p>4) 2 rates will be less confusing. There needs to be clear guidance around the rates and</p>

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	<p>criteria for consideration of which rate applies and that there is recognition that as needs vary so do the rates.</p> <p>If there are only 2 rates there may be less flexibility in terms of qualifying criteria</p> <p>5) there should not be an automatic entitlement. This in itself is discriminatory. The benefit should be considered on individual functional need.</p> <p>6) this should be prioritised on an assessed needs basis using the additional information of such others as medical and allied health professionals. Full functional assessment such as that undertaken by Occupational Therapists should underpin decisions.</p> <p>Essential activities include those which can be considered in the three main areas of self care, leisure and productivity which would also include vocational activity in its broadest sense, not just full time paid work</p> <p>7) build in regular review criteria along sensible timescales, these might need to be flexible depending on the underlying cause of the disability and its potential course. These need to be made explicit when an initial decision is made with regard to the rate and component of the benefit and come as no surprise to the claimant. The responsibility for undertaking such reviews should remain with the DWP and penalties should NOT be attached to any delay in completing a review. Please get rid of such questions as how often and for how long do you need this support - as a disabled person myself (blind) - these are almost impossible to answer accurately. Support needs vary and are dependant on a huge range of other considerations and circumstances.</p> <p>8) all aids and adaptations should be included in the assessment. The cost of purchasing such aids and, maintaining and replacing them also needs to be factored in. Certain aids are very expensive and cheaper options do not work as effectively. This should be about making things easier for disabled people not giving them yet more hoops to jump through. future needs must be considered and should be considered in the same way as varying and fluctuating conditions. E;G - a person might be able to walk on one day and not on the next, thus their mobility needs vary and the support should accommodate this.</p> <p>9) don't ask about how often and for how long each time support is needed - this is impossible to generalise.</p> <p>Make it shorter - it's distressing to people as it is so long. Retain the facility to make on line applications.</p> <p>open up the range of additional people who can contribute to the assessment (OTs, physios, carers.....)</p> <p>Facilitate face to face sessions / interviews which are designed to help people fill out the form ( forms are almost impossible in hard copy for partially sighted people) not everyone has access to the internet.</p> <p>Provide a TV and radio media coverage about the changes to the benefit. Enlist the support of citizen's advice bureaux and other disabled people's organisations.</p> <p>10) Occupational Therapists full functional assessments. Contact the College Of Occupational Therapists in London for further information about this professional service.</p> <p>11) this will allow issues to be explored, it might be anxiety provoking for individuals, especially for those with mental health problems. It needs to be done in the claimant's first language. People might not attend for a variety of reasons and this should not incur penalties. Home visits should be offered as a matter of course - you are dealing with disabled people with mobility problems!</p> <p>Use Occupational Therapists in the first instance - this is their daily work!</p> <p>12) reviews should be arranged in sensible timescales depending on the underlying condition, its possible course and associated functional changes.</p> <p>the reviews need to be designed around individual presentation and need - one size does not fit all.</p> <p>13) people are not always aware or have insight into their changing needs, what is the opportunity to engage advocacy services to support this?</p> <p>Could reminders be sent to people every 6 months to ask if their needs have changed?</p> <p>People are often afraid that if they report changes that their benefit will stop. In some cases this is appropriately the case but in others it is not.</p> <p>?) yes, if the initial application process included the facility for the claimant to name another person that they could appoint as an alternative contact this might help in increasing the response rate amongst this group of people. People with mental health needs would benefit greatly from this addition to the process.</p> <p>?) this is varied, some aids and equipment are provided either free of charge or on a means tested basis but other equipment is not funded. Good quality technological</p>

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	<p>equipment is vital to support independence, it needs to be situated in a place where it is most effective and in some cases equipment might need to be duplicated. One off costs should be considered as part of the new PIP as should replacement, maintenance and upgrade costs.</p> <p>?) the needs of the wider family in which the child is living.</p> <p>respite provision should also be supported, not only for children but for the most disabled.</p> <p>?) provide a map of linked benefits and provisions to help disabled people make informed choices about how and what they claim and the impacts of claiming on their other obligations.</p> <p>?) confusion, potential underclaiming of other necessary support, lack of clear accessible information, hardship</p> <p>?) joined up assessment to meet broad criteria. Single point of access to information about individual</p> <p>?) no additional comments</p> <p>?) no thank you</p>
ONLINE271	<p>1) Lack of early intervention and poor quality / lack suitable education leading to poor outcomes, particularly for children on the autistic spectrum. Children with normal or high IQ but with autism significantly underperforming. Lack of willingness to employ disabled people, not just those with physical disabilities but those with learning disabilities or autism. For autism lack of social skills is more relevant to outcome than education or educational qualifications but little education is devoted to social skills. Complete absence of an autism strategy for children that has any evidence base to it. Complete lack of outcomes based interventions. UK autism intervention being decades behind that in best USA practice. Lack of jobs, or underemployment, leads to low incomes and dependence on benefits. Inability to afford good housing, transport, leisure activities. Income limited to necessities only. Access to higher education prohibited by cost - is it worth sending my bright autistic son to university for £9,000 fees per year + living costs if no-one will ever employ him at graduate level? Public intolerance of difference. Mental health problems and depression. Inadequate mental health services. Broken SEN system where there are incentives to local authorities to deny provision for as long as possible. Lack of affordable housing. Lack of supported housing. Lack of thought in design to people with sensory needs eg children with autism who are sensitive to light or sound bombarded with sensory stimuli. eg noisy hand dryers not paper towels make public toilets inaccessible for children with sensory problems. Parents unable to work means children raised in low income households, parenting a disabled child costs three times as much as a non disabled child and parents ability to work is severely reduced leading to a double whammy which is not recognised in the benefits system,</p> <p>2) More assessments, more form filling, more stress, more fighting for basic provision.</p> <p>3) Therapy eg for an autistic child the intervention provided by the State particularly for under fives is so inadequate parents are forced to pay for private therapy. Higher costs of childcare (if there is any which there often isn't). Aids and equipment. Legal costs to fight for provision. Incontinence products. Adaptations eg to car / house. Insurance. Housing - may need room for carer. Transport costs eg may need taxis instead walking / public transport. Higher holiday costs eg if need to take carer.</p> <p>Costs of disability go well beyond mobility and daily living. Issues such as lower income eg if cannot obtain employment or cannot work fulltime not taken into account. Also cost of parenting a disabled child not taken into account. Many parents rely on DLA both to pay for things their child needs, but also to replace lost income as they cannot work but have to do unpaid caring instead. Due to lower income many disabled people excluded from housing and have to live with parents long term. the expense to parents is not reflected anywhere in the system. Many parents of children with autism fear their DLA will be cut as their children's disability is hidden - eg they can walk. Will assessments take into account the high level of care needed for autism? Children with autism usually cannot tolerate long periods of childcare - autism has the biggest impact on parental finances of any disability. Children with autism cannot tolerate change or care by different people / different settings. Parents lives are very restricted. The current system does not recognise the increased costs to parents. Some parents fear they will have to ask for their children to be taken into care if DLA is cut as they cannot work and cannot afford to live without their child's DLA. Carers allowance / tax credits are completely inadequate and do not reflect the true costs of a disabled child to a family. My husband and I used to jointly earn £70,000. We now have a joint income of £25,000 (2 part time salaries) as our child needs fulltime care and</p>

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	<p>its too intensive for 1 of us to do this. £50 a week carers allowance does not begin to cover our lost income. In addition we have to pay out more eg private therapy, legal costs for SEN tribunal. We have no pension and no savings. We face a life of poverty because one of our children is disabled. DLA does not look at any of this nor does any other benefit look at this. DLA - although only a small contribution to what we have lost - has been the difference between keeping our head above water and losing our home. Any change to the benefits system must look to adequately provide an income for parents who are more often than not forced to give up work to care because childcare or other provision is wholly inadequate or non existent and does not cover a full working week.</p> <p>5) For children, yes. Any severe developmental delay. It should be recognised that this will have an extremely damaging impact on the family's income and that parenting a disabled child is known to be three times more costly than a non disabled child - there should be an automatic eligibility for severe conditions eg autism, GDD, severe behavioural problems, CP, Downs etc. This could be reviewed at set intervals eg 5, 11, 14 as some children do make progress but this is rarely dramatic.</p> <p>10) There should be a recognition that much evidence relating to SEN needs it not clear nor impartial. Many reports for statementing are written to resources not need and as such are not an accurate reflection of a child's needs.</p> <p>11) Yes many people or children with autism would find this very difficult, may be unable to advocate for themselves, can find strangers frightening.</p> <p>17) The costs of parenting a disabled child are massive (three times the norm) whether that child gets specialist schooling or not. For eg my child does now get specialist provision so our private therapy costs have decreased, but we now have to drive him many miles a week to access that provision. We also cannot work as the provision is only in short bursts. DLA massively underestimates the costs especially as it does not take into account the need to subsidise poor education and therapy. eg SALT, autism therapy, OT, physio - many many parents pay for this privately out of DLA. DLA however tends to look only at mobility and care - not at costs of maximising a child's outcome. Any review of the system needs to understand carers allowance is not a living wage. Even in special school parents can often not access before or after school clubs or holiday provision and need to attend multiple appointments. The effect on parental income / inability to work is not reflected in the current system. Many parents think they will be forced to put their children into care if DLA is cut. Frequent review is also an added stress to the many other assessments which take place. Children should be put into broad categories of severe, moderate or mild and DLA awarded on a global basis. Any long term condition or severe delay or developmental disorder should merit the highest rate and be reviewed at say 5, 11 and 14. Often children with high level physical needs or very challenging behaviour get better public provision than children with ASD who are seen as less disabled and don't meet eligibility criteria for many services eg short breaks - but the impact of parenting a child with autism can be just as devastating and expensive. SEN assessments are frequently inaccurate being written to resources not need.</p> <p>?) More thought as to hidden disabilities eg autism and how non specialists are going to assess this especially for people with high functioning autism who may still have significant care or social needs.</p> <p>?) Yes include behavioural problems in the mobility criteria so people with autism can get blue badges - parents can find it very difficult to manage children who refuse to walk. Extend grants to disabled children to those on low incomes rather than just those on income benefits.</p>
ONLINE272	<p>1) It isn't external barriers - it is the reality of the disability - ie unable to speak, wearing nappies, needing to be fed. Nothing can change these... what DLA does ( for us) is to pay for some of these things to be paid for!</p> <p>2) Yes, it takes in to account the persons needs and the cost of coping with them</p> <p>3) Cost of carers to do the caring  Cost of extra washing and heating  Cost of petrol to drive seriously disabled person around to calm him  Cost of more expensive foods to attempt to make undernourished person eat  Cost of going to anything which may amuse and entertain person for even a few minutes</p> <p>4) Anything which make sit more complicated to claim or understand is BAD!</p> <p>5) Some conditions don't change, always have implications for the person, not worth changing the system - bound to make it more complicated</p> <p>6) This completely misunderstands the issues. My 3 disabled "children" (aged 17 18 23)</p>

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	<p>don't want to just lead full and active lives- they need DLA to help pay for the most mundane items - nappies/ to pay for the hot water to wash all their bedding every day and to pay for (charity shop) clothes to replace the ones that my son eats every day of his life! The cost of being disabled are not paid for in any other way - unless we put any of them into residential care, when you, the Govt will have far higher costs to pay!</p>
ONLINE273	<p>5) I was a lone parent adviser before my current job.I noticed how many of our lone parents had children with ADHD and how many were claiming DLA for them.I was surprised to see how much money they were getting and that DLA mobility was included.When I asked what they used the money for they said things like X box games,going pictures and some did'nt seem to know why they got the money.I can see why a severley disabled child who needs help feeding,dressing going toilet etc should get the money but why does ADHD attract the same amount of money.The extra costs involved do not compare.</p> <p>10) The new benefit should be reviewed more often.As a crisis loan officer I regularly see people who receive DLA but do not seem to be entitled.There seems to be a lot of people who can walk perfectly well but they get mobility component of DLA.This includes people with drink and drugs problems,depression and young adults with ADHD.I have queried this and been told they may need someone to watch them walk but surely we should not be using DLA for this.We need to be stricter about who we pay so that it goes to the right people.</p>
ONLINE274	<p>3) Travel costs to hospital apts, and social activites which are assessable. Costs to learn British Sign Language so that I can communicate with my son as college courses are not free, yet someone can learn english as a second language for free - Why? In the early days, money was needed to pay for extra washing, and clothing as my son was constantly sick due to tube feeding. I was also unable to work due to the numerous apts, and had no choice but to stay at home regardless of our financial situation,</p> <p>5) I can not see how individuals assessments will work when carried out by staff who have little understanding of disability. I phoned the helpline to ask why my son's benefit would be reviewed only to be told that it was because his deafness would improve! As a mother coming to terms with his diagnosis, I found it shocking that someone (who was eating at the time) could say this. It was totally untrue - my son remains severly deaf, and I have no confidence in the staff who work at DLA.</p>
ONLINE275	<p>5) HOW WILL THIS BE WORKED OUT WITH SOMEONE WHO HAS RELAPSING AND REMITTING MULTIPLE SCLEROSIS SURELY IF YOU DO NOT KNOW WHEN YOU WILL BE ABLE TO WALK, TALK, SEE,ETC NEXT IT IS DIFFICULT IF NOT IMPOSSIBLE FOR SOMEONE TO WORK IT OUT BY SIMPLY TALKING TO YOU . AND HOW CAN WE EXPECT EMPLOYERS TO UNDRSTAND OR SUPPORT SOMEONE WHO COULD POSSIBLY BE OFF WORK FAR MORE THAN THEY ARE THERE. ARE THERE ANY PRPOSALS ABOUT HOW THESE DECISIONS WILL BE MADE, AND WOULD THE CLAIMANTS OWN gp or specialists opinions be taken into account</p> <p>5) yes relapsing remitting multiple sclerosis exahstion is constant but if i do not know if i will be able to walk , talk, see, understand anyone etc on a day to day baisis and this has been proven by scans etc , how will a piece of paper be able to work it out . have you made any plans for these type of conditions</p>
ONLINE276	<p>1) The biggest barrier is the disability itself. My son has Autism &amp; Profound Learning Disability. Living with him is very stressful and difficult, as is taking him out. We need money for respite (without a break from caring our son would be in a residential school), we need places that he can visit without endangering himself and others, we need money to pay for help and support for our family.</p> <p>4) I think it is appropriate to have different rates because there are vast differences in severity of disability. Important that needs are accurately assessed. In order for our son to venture out of the house, he needs a specialist carer to be able to hold on to him and guide him at all times, to prevent him endangering himself or others or damaging property, which is very expensive. He receives higher rate mobility component because of this severe mental impairment.</p> <p>5) People should be individually assessed because there is usually a wide variation in ability within each disability.</p> <p>11) The healthcare professional needs to be someone who knows the disabled person well and has a clear understanding of their particular disability.</p> <p>?) Yes of course, but receiving the payment should not prevent them from accessing Local</p>

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	<p>Authority grants. Disabled people need to be able to spend the money on whatever they want and need. There should be no government interference in this.</p>
ONLINE277	<p>1) LACK OF SUITABLE PUBLIC TRANSPORT ESPECIALLY ROUTES WHERE NEEDED.  LACK OF PROPERELY MAINTAINED ROADS AND FOOTPATHS ESPECIALLY WITH A LACK OF DROPPED KERBS AND INCONSIDERATE PARKING ACROSS AVAILABLE DROPPED KERBS.  COST OF PURCHASING, MAINTAINING AND CARING FOR ALL DISABLED EQUIPMENT.  FUEL DUTIES AND INCREASING COSTS ESPECIALLY FOR RECHARGING ELECTRIC POWERCHAIRS AND SCOOTERS.  COST OF ALL DIABLED AIDS DESPITE VAT CONCESSIONS SMALL ITEMS ARE VERY EXPENSIVE.  LACK OF DDA COMPLIANCE IN BUILDINGS, SHOPS CINEMAS, THEATRES OFFICES ETC.  LACK OF HELP AND UNDERSTANDING FROM SOME POLICE FORCES EG. EPILEPTIC/DIABETIC CONDITIONS MISTAKEN FOR DRINK/DRUGS.  2) IF A DISABLED PERSON USES AIDS FOR EXAMPLE STICKS, CRUTCHES WHEELCHAIRS, POERCHAIRS OR MAYB SCOOTERS THESE ARE ALL AIDS TO GETTING ABOUT AND SHOULD NOT BE USED AS AN EXCUSE TO BAR THE PAYMENT OF DLA (HELP FOR GETTING AROUND) AS HAS BEEN MOOTED.</p>
ONLINE278	<p>3) Transport costs to and from hospitals and doctors.  5) One of the key issues in the application process and the reviews every five years is the need to constantly re-state an individuals condition. Where am individual has a permanent condition like Down's Syndrome for example I do feel it should be automatic. Having to focus on every detail of what an individual can or cannot do is degrading for the individual and their family. Whilst it may be true to say that individual's with Down's Syndrome vary in their ability - as does hte general human population - nevertheless the fact of having Down's Syndrome and the fact that this results in some degree of impairment remains constant. I feel an award should be made at birth for certain conditions and left in place for life.  7) The current rules on residency are a nonsense and whether DLA is exportable or not depends on when your award was made and does not relate in any way to your condition. This is plainly ridiculous. British citizens continue to be disabled when moving overseas and we need to decide whether or not we support Brits who choose to leave the UK or we do not. There should not be any variability in this. I do not agree with payments stopping when someone is hospitalised - for the family this is a time when costs are highest with travelling, extra childcare for other family members and the exorbitant fees to park at hospitals.  13) Make it easier! Email communication rather than reams of paper. Some conditions e.g. Asperger's, ADHD for instance mean that these groups would find it much harder to remember to report changes so where there is no appointee in place perhaps some groups could be sent reminder questions to ask if anything has changed.</p>
ONLINE279	<p>1) Tailored support to meet individual needs through allocation of support workers, equipment and transport. There remains a heavy reliance on families offering significant support especially as a back up to services when they fail to deliver due to understaffing or severe weather conditions.  2) Access/entitlement to other services and benefits  3) Transport - purchase of vehicle is higher when required for a wheelchair user - insurance has to be fully comprehensive to allow for any driver of any age - cost of maintaining vehicles is higher when wheelchair conversion has extra fittings and there are additional inspections and servicing.  Equipment - some equipment is not covered by NHS agreements ie. hoists and repairs and servicing (servicing has to be every six months) and the cost is met by the user when the initial agreement expires.  Utilities - heating has to be maintained higher than average when someone is fairly immobile, also extra washing and drying for incontinence/salivating/ difficulties with eating and drinking.  Household equipment - Gadgets to help with independence are an additional cost.</p>

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	<p>Purchase of specialist equipment - communication aids for those with complex needs are expensive and extremely difficult to obtain. Technical support for this has also to be purchased. Also training of support workers is an extra cost.</p> <p>Individuals with complex needs very rarely have a break unless families take on the role of 24 hr caring and contribute towards accommodation/travel themselves, this is because the extra cost of having a holiday is too high for the facilities required including equipment; extra bedrooms for care workers and suitable ensuite/bathing.</p> <p>4) One component already has two rates. The rating of each component is a practical approach as it would not be cost effective to tailor each benefit to individual needs which would be likely to increase bureaucratic processes. However, it is important to have clear criteria; consistent assessors and the ability for individuals to challenge decisions where their needs are borderline between higher and lower rates. Where the case is borderline, a person should receive the higher rate to avoid unnecessary hardship.</p> <p>5) Some health conditions or impairments should have an automatic entitlement to the benefit and allow for the individual to request a review if their needs and circumstances are greater than assumed.</p> <p>For example, where someone is quadriplegic; non-verbal; with health conditions and learning difficulties or someone that has a terminal condition. It is a nonsense to waste time and resources and provide additional stress to individuals and families in going through a claims process. It should suffice to have a GP's or consultant's report.</p> <p>6) The following list is not in order of priority, however it is important to begin with the individual and ensure they feel in control of their life.</p> <ol style="list-style-type: none"> <li>1. Having control (person-centred) means planning and reviewing and engaging the individual in those activities</li> <li>2. Maintaining independence - requires support for using and developing skills ie, physical, communication, cognitive, social. The most basic is attending to personal hygiene, feeding, dressing and keeping safe.</li> <li>3. Health - being as active as possible it shouldn't be assumed that any condition prevents physical activity of any sort; taking medication; healthy diet and having emotional support</li> <li>4. To lead as meaningful a life as possible - we feel fulfilled when we have achieved something others can appreciate. Engaging in meaningful activity should not automatically prevent access to benefits.</li> <li>7) The individual and their main carers should contribute to the assessment by giving examples of fluctuations. Medical opinion should be sought where the individual suffers from a serious health condition stating the prognosis and also giving examples</li> <li>8) Aids and adaptations are often an additional cost to some people as not all are covered by financial support from Local Authorities and that ought to be considered in the DLA reform. Unless the assessor is going to support the applicant's process of applying for an aids and adaptations assessment. It makes no sense for a assessor to anticipate what aids and adaptations are suitable unless the assessor is qualified in that area of work.</li> <li>9) Give support for completing the form when requested and provide online images; arrows; flowcharts; instructions.</li> </ol> <p>Where an individual has a serious health condition or disability it should suffice to simply describe the condition and provide evidence from a GP; consultant; health professional.</p> <p>10) A clear description from the individual, main carer and health professional. Health professional to provide a recent report and their opinion/prognosis</p> <p>11) There are sensitivities or mistrust where a healthcare professional not previously known to an individual is involved in an assessment for a claim. It makes sense for a healthcare professional already involved with the individual to deal with the evidence to support a claim where possible.</p> <p>12) Anyone with a long term condition already identified should not require a review. Frequency of reviews should depend on the prognosis</p> <p>?) This online form is not easy to use, and is not accessible disabled people.</p> <p>?) Claimants would have delays and difficulties in accessing other benefits and services while they wait for other assessments.</p> <p>?) Accessing services for the families, especially the main carers, is important and should be included in the new claim process. This will make the carer feel valued and it will be encouraging for them to know that their needs are going to be considered at the same time</p> <p>?) Reducing the amount of assessments an individual has to tolerate is important. It should automatically lead to other benefits.</p> <p>?) Many people assume that an individual with cerebral palsy have only a physical</p>

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	<p>difficulty. The impact of cerebral palsy on an individual can vary greatly from mild to severe (similar to the autistic spectrum) and no assumptions should be made about how straight forward it is to overcome this with aids and adaptations. This is a condition for life that can worsen over time. There is evidence that disabled people (or families of) in Asian communities are less likely to seek support.</p> <p>?) The advice and information people seek is often about the following:            What are other benefit entitlements?            What equipment/adaptations are available?            What support is available for them?            What support is available for their carer/family</p> <p>It would certainly help to provide advice and information at the time of claiming if they state they haven't received any.</p> <p>?) It would be difficult to insist that anyone accesses advice and support as it would depend on their circumstances and how effective those services are. Far more effective to ask claimants to state what they think they could benefit from and then give them support in obtaining it or discussing it with an experienced person who has the same condition/circumstances through a support group.</p> <p>?) By informing and supporting the individual and through reviews.</p> <p>?) It is difficult to assess a child's ability or understand how stable their condition is/will be. It is also difficult to understand the impact on the family of having a child with a serious health condition/disability. There are greater sensitivities involved. Parents often strive for a sense of normality in their family and will generally cope with their child's needs until breaking point and when that happens it is necessary to act quickly to relieve the pressure. Parents need to be assured that claiming benefits before breaking point is in their and their child's interests and isn't an acknowledgement of their failure to cope.</p> <p>?) It is not always possible to obtain all aids and adaptations through NHS/Local Authorities and I do think that some funding should be available for this. Note: there are additional costs in having some aids ie. maintenance; repairs and training for the individual and those supporting the individual.</p>
ONLINE280	1) test
ONLINE281	<p>1) I was diagnosed with MS in 1981, staying in Relapse and Remission until 2000 when I started to deteriorate and I am now confined to an electric wheelchair needing carers to get me in and out of bed, using a hoist into my wheelchair. People suffering from MS may have a chronic long term condition, but in the early days, every day was different. How are you going support that with PIP. Even though we've had the DDA for some years, I have still faced barriers whether it's getting into a building, public transport or in my working life when applying for jobs. Now friends who live in residential care are going to have their independence totally reduced by you removing the Mobility section on any benefit whether it's called DLA or PIP. Why do you presume that living in residential care means a young or elderly person no longer wants to or needs to go out. I am totally reliant on the mobility part of the DLA as I have a grant from Motability to have a wheelchair accessible vehicle converted, so that I can drive from my wheelchair. I live in a rural village in Norfolk and have no way of going out other than with 1 very expensive wheelchair friendly taxi. If you take away that benefit then I can no longer sit on all the different committees from the [REDACTED] Regional Newsletter to over 2,000 members, the [REDACTED] of which I am [REDACTED], the [REDACTED] of the MS Society and the Norfolk Coalition of Disabled People, besides living an active and enjoyable life. I may not have legs that work like a lot of friends with a disability, but we must go on having our independence. I agree that the DLA does need reform, but please don't take us back 20/30 years when just because we have a disability you have to lock us up and throw away the key as we become an embarrassment to Society.</p> <p>2) It is important that you leave the mobility side of the DLA/PIP in place. Without that most disabled people will be confined to their homes. Paying for taxis or other forms of transport are cost prohibitive with DLA, even going to hospital appointments. Using ambulances are a drain on the NHS. The cost of living for someone disabled is much higher, especially when so much equipment is no longer provided due to cutbacks. My career was cut short due to my MS, so that my final salary at pension age was so much</p>

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	<p>smaller. I even had to pay for my own electric wheelchair because I was originally turned down by my local county wheelchair assessment on the whim of an individual. The grant available for home adaptations is severely being cut and is of course means tested, as well as waiting for at least 2 years to get it!</p> <p>3) The cost of transport if public transport is not available to you. I live in a rural village, where this is an infrequent bus service but at present the buses do not have to be wheelchair accessible until 2015 at the earliest! If I could get to my nearest railway station 18 miles away traveling by rail is not always possible. Therefore without Motability and my grant from them to drive my own converted drive from wheelchair vehicle, which of course is reliant on me receiving the mobility part of the DLA or PIP I would never be able to leave my own house unless I use a very expensive wheelchair accessible taxi at least £40 to go 5 miles return and £90 - £100 to go 20 miles return!</p> <p>In addition adaptations, there was no guarantee that I would even get the adaptations grant after 2 years so we paid for our bathroom to be adapted into a wet room. I know several other people who have also scrimped and saved to do the same. I'd waited 5 years to access my own toilet!</p> <p>I could only afford a second hand electric rigid framed wheelchair on eBay as I was turned down by wheelchair assessment. If hadn't bought it myself I would not have got the grant from Motability!</p> <p>I am lucky that my hospital bed, pressure relieving mattress, hoist, slings and shower chair have been provided as I can't imagine what would have happened if we'd had to pay for these ourselves. The cost to Social Services would have been much higher to have me living in residential care. I also believe I would have committed suicide if that had happened. I know what it is like to stay in residential care! So it is not just financial costs you are talking about.</p> <p>4) It is hard to say. The current forms are very complicated and I know several people with MS have great difficult writing so are reliant on someone else completing them. Hopefully having 2 rates per component will make easier to understand proving you don't leave something important out. It is easier to complete the forms now that you can do it on line as editing while you go does help. I presume this will also be possible with PIP. The idea of someone assessing you but you not being able to see what they have written will not be satisfactory. I have always kept a copy of anything I have sent in regarding DLA.</p> <p>5) As someone with MS, a long term condition, who is now in secondary progressive stage. I will no longer have remissions or will ever improve. My situation will only get worse. I am aware, as I was in relapse and remission for many years, that there are good days and bad days. I believe you should listen to the MS Society and other relevant Organisations, who will be the best people to advise you on their behalf. I feel having to reapply every 3 years, when it is obvious that things will not improve, is just another nail in my coffin! What are you going to do about Motability? I have a wheelchair accessible vehicle that due to the cost and complexities of the adaptation is on lease to me for 5 years. Wouldn't it be better for people who are at an obvious stage in their disease to be asked to re-apply, if must, every 5 or even 10 years, or even better stay for life!</p> <p>8) If you take away all the different adaptations that I have paid for and have been supplied to me I would never be able to get into and out of my bungalow. I would have difficulty in going through some doorways, for instance into my bedroom and wet room. I would never be able to get into or out of my bed, without my slings, my ceiling hoist and any carers, including my husband, would all have bad backs, because most beds are too low!! I would never be able to turn without my bed lever, sit up without my full profiling bed, I would probably be in and out of hospital as my pressure sores on my feet and legs would be so much worse without my pressure relieving mattress. If you took away my current electric wheelchair, which helps to improve my posture and pain, I can't imagine how life would be like now. I'd be in bed all the time without an electric wheelchair, but then you wouldn't have to worry, as if that was all my life was, baring in mind, I am lucky to still have the power of speech, thought and mind. I would be another statistic, but this time I hope it would be like a lot of other disabled people, on your conscience, because I would give up the fight for life and commit suicide.</p> <p>Please don't make it any harder for us to fulfill an active and happy life by having these pieces of equipment and adaptations taken away. I suppose if you get your way you will say, I don't need any benefits, you're already giving it to me in kind.</p> <p>9) It certainly needs simplifying. Although it is so difficult as it has to deal with such a diverse audience and range of disabilities etc. It certainly helps me to do it on line as I can</p>

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	<p>then edit, go back when I need, as I find writing by hand very hard now. I presume you will be talking and trying out different ways of doing the forms in a trial situation with disabled people. Publicising and working with the different disabled organisations such as MS Society, Leonard Cheshire etc is a must.</p> <p>10) I don't believe you will get an accurate picture of the person's needs without talking to their GP. Yes having an assessment by a professional is good but how do you assess someone you don't know in a few hours. It can be a frightening experience being assessed, after all what they write and decide can make or break someone's life. Some people are intimidated by such an interviews. People with mental health issues or learning difficulties, for instance. Surely they must have someone with them who knows them well and can reassure them. Why could it not be done with a person such a competent carer, family member or GP in attendance. It's going to cost a lot for such assessments that covering the cost of a GP or other professional won't be impossible.</p> <p>13) This is a very difficult area. I believe most people do not want to defraud the system, but if you have a fluctuating disease then the fear is as soon as you notify the DWP of the changes they can all come back and you have to reapply which takes so long. I know there a small number of people who abuse the system and they need weeding out as they do with the Blue Badge system too. How you do it without causing worries and pain to all the other I don't know, I wish I did.</p> <p>14) The more cross referencing between the NHS, Social Services and other areas of benefits and support the better. In the early days of my diagnosis and then needing simple support like continence pads etc., my GP, originally in Birmingham, knew nothing. It's different here in Norfolk as I have an excellent GP. I didn't know about DLA, and all other support until I was off my legs and in hospital and I couldn't come home until all the equipment and care was in place, so the more you can do to signpost and vice versa the better. That will stop so much unnecessary duplication. But you still need to give us the financial benefits and support in DLA/PIPS to give us independent lives.</p> <p>15) Without a doubt. Work with GP's and Consultants and any other areas that people come into contact with when a person first becomes disabled or diagnosed with a progressive or long-term condition, to let the person what support there is available when they need it.</p> <p>16) If people aren't lucky to get their aids and adaptations for free or partially funded by means testing, then they have to scrimp and save and go without other essential items, like heat and food to buy them. I don't using such payments as PIPS to cover such items will help as then removing the benefits for care or mobility will cut other living costs. If it was known that such an item was needed then maybe a grant system could be put in place as you have with Motability.</p> <p>?) I do believe that cross referencing between departments could be useful to avoid all these different assessments. The worry is that someone could be penalised and this private information could get into the wrong hands. I am of the opinion, there is nothing to worry about if you have nothing to hide. The people who need to know about my disability and health issues should be able to cross reference as they can do with my hospital files. It makes life so much easier and helpful.</p> <p>?) Even though we have the DDA for at least 15 years, and now have new Disability and Equality Act 2010, disabled people face difficulties with access not only to buildings but public transport etc., but employment too. I am confined to an electric wheelchair as I have MS. I was diagnosed in 1981 and have seen so many good changes in society towards disabled people, but I am still surprised at how far society still has to go to accept people, whether it's people with mental health issues, learning difficulties or other disabilities. We still don't know how to deal with our elderly, but hopefully we are learning to respect their experiences. I look forward to 2012 with the Paralympics in this country, so that people in the UK can see disabled people on their doorsteps, so to speak, on their TV's and in in their every day lives. People from around the world will see first hand how we relate and accept disabled people and understand how important it is to be allowed to participate in all aspects of Society. We are only disabled because Society makes us disabled.</p> <p>?) It's very important, but I am not convinced that up to now it has been as affective as it could be. You need to shout louder and highlight where people can get this help both using your website and through other Government publicity.</p>
ONLINE282	<p>1) The main problem I had, was to be able to get anywhere. Taxi's are too expensive and I am unable to walk far enough to get to a bus stop. Also many disabled people feel isolated and on the fringe of society which only seems to tolerate them at the best of times.</p>

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	<p>2) The mobility component is a very important one for me. It has allowed me to become independent again. Prior to getting the benefit, My mum would have to take me to hospital appointments and work and take the kids to school. Now I have an automatic, I can do this for myself again! Personally I think that there should be no changes to this benefit, as it is almost impossible to get anyway! It took me nearly two years and a visit from a medical practitioner to get this benefit, not to mention the stress of numerous appeals! I am really frightened of having to go through this again! Just the thought of it is enough to make me feel ill and stressed out.</p> <p>3) The main costs I face are the travelling and living expenses. travelling to and from hospital for appointments and to and from work, all costs money as does heating the house - a big problem for me as I really feel the cold these days! My Heating this winter has been astronomical and If not for my DLA, I would have had far more infections than I had as I could not have afforded to put my heating on!</p> <p>4) It may be easier for the administrators but not be for individuals! When filling in the forms It is difficult to think about how you do things - as you have to do them the best you can - two people with the same condition may be able to do completely different things every day, but both will need the help and support that the DLA provides, just in different ways; you cannot have a blanket approach with this as people are individuals and may or may not need different levels of help. But will still need help. I think if you change this then more people will fall from this badly needed help - but if that is what you are aiming to achieve then go for it!</p> <p>5) I believe that certain conditions should be eligible for automatic entitlement, for example conditions that are not going to improve or are going to get progressively worse over a period of time. Having Chronic Lung Disease, I know that my condition is going to get worse over time, and if i then have to reapply every few years, this will cause undue stress and fear and would probably excasibate the ongoing condition. If based on the needs and circumstances how would that be implemented? What would the critera be? It could end up that two people with the same condition apply for this new benefit, but only one gets it! Is that putting the individual needs first - no!</p>
ONLINE283	<p>1) Inaccessible public transport.  Living costs  Inability to find suitable, part-time or working from home employment  Inaccessibe shops, cinema, restaurants, cafes etc  Poor quality of footpaths  Lack of suitably adapted properties</p> <p>1) Public Transport is largely inaccessible to disabled people. Growing hostility to disabled people.  Inability to access support.  Difficulties finding work.  Difficulties getting support if in a job - either from government or employers.</p> <p>2) It should stay as it is. DLA is a life support for many disabled people. Leave it alone. A new benefit is NOT needed.</p> <p>3) Transport - as public transport is largely inaccessible  Adaptations to home  Food bills- these can be much higher as disabled people may need to buy either pre-cooked meals or fruit and vegetables that are pre-prepared  Prescription costs  Reduced earnings from work if able to find a job - as need to work part-time or reduced hours thus affecting salary and probably pension as well.  Holiday costs - if can afford holiday, the costs are higher as need to find accessible accomodation etc  Costs of complementary medicine and treatments  Heating costs - as unable to move as much will suffer from cold more  Airconditioning in summer if suffer from diseases like MS where heat can exacerbate symptoms.  Help with cleaning house etc.  Walking sticks, crutches, wheelchairs, scooters.</p> <p>4) This is no different to the current structure for DLA. This proposal is therefore ridiculous. DLA is already hard enough to get, this won't make it any easier. If anything it will make it more difficult. The proposals are not a simplification, they are more confusing and will make the benefit largely inaccessible to those who need it to support them in their day to</p>

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	<p>day life. Please leave DLA untouched.</p> <p>5) Assessments simply mean more stress for disabled people. I would like to see the range of health conditions or impairments that mean an automatic entitlement to DLA widened.</p> <p>Failing that, please leave DLA as it is. It is not easy to access, so the system is already excluding people who need it. Why make it harder? It should be simplified.</p> <p>6) Isn't the social model of disability a bit out-moded? Maybe you need to find a different model?</p> <p>If you want to prioritise support, then leave DLA as it is. The most essential activity for everyday life is living. What activities are essential change daily. This cannot be charted on a grid.</p> <p>My essential daily activity on a Monday might be washing my hair and not then being too exhausted to go to work.</p> <p>This may not apply on a Tuesday, then it might be getting my rubbish into the bin for collection.</p> <p>Or it might be just getting out of bed and getting dressed.</p> <p>The advantage of DLA is that as it is paid on the medical model of disability, it allows the recipient to use the allowance flexibly and according to the individual's needs. I do not see how an assessment such as is being proposed can see the daily and sometimes minute changes that might affect the essential activities on a day by day basis. If I have had a stressful day at work, I may not have the energy to turn on the stove, so I will need something already prepared. This is difficult to plan in advance for , so DLA allows the recipient to react on an as and when basis to needs. Your proposals seek to put everyone in a box or category and disability is not like that.</p> <p>7) I doubt if you can ensure that. Your assessment would have to be done by someone who is completely familiar with the condition and the many ways it can affect people. The problem with variable and fluctuating conditions often differ from one sufferer to the next. Only the individual's GP, and hospital team, have sufficient familiarity with the individual to comment on their abilities and needs. So the medical model for assessing this is better and should be left as it is.</p>
ONLINE284	<p>5) Hi, I believe anyone having received a payment for Vaccine Damage should receive automatic entitlement. The criteria for receiving the Vaccine Damage Payment is currently being assessed as 80% disabled. The fact of being damaged by a vaccine is that a formerly healthy child or even adult who submits themselves to the government run vaccine programme and consequently as a result of that vaccine becomes severely disabled, is hard enough to live with without being subjected to assessments to prove entitlement. The current one off vaccine damage payment in no way covers the loss of earning ability and the catastrophic impact of being severely disabled. The government should be more than willing to support innocent individuals who are damaged as the benefits of vaccinations for the nation as a whole far outweigh the few people who will suffer adversely to the vaccine.</p>
ONLINE285	<p>1) The impact that their disability has on them on a daily basis. For example, time restrictions, ability to sustain restrictions. Lack of support, Lack of belief. Ignorance of others.</p> <p>2) Yes, It should still remain to be a non means tested benefit. It should still assess the help required for personal care and mobility,</p> <p>3) Travelling costs. For example, a family car may already exist but used by one of the partners for travelling to work. The person who is disabled will then either be required to use public transport (buses) if suitable for them, taxi's if not. Or in my own case, so that I would have even more independence an additional car, requiring additional hp, Tax, insurance maintenance petrol. This then allows me to go out when my condition permits, I can have total control with my own vehicle eg getting parked as close as I need. If out shopping and need to go to several shops each a distance away, or a bank then post office then chemist, I can park close to each.</p> <p>Regarding personal care, additional heating costs, additional washing costs, health suppliments, hygiene products necessary in addition to normal family ones. Paying for help such as someone who actually assists me to carryout household tasks which cannot be done in total by myself but with assistance at least I can contribute and have a some self worth and pride. On holiday you have to pay for priority boarding, extra leg room. Cant always avail of the cheapest flights because the times dont suit when your at your worst ie</p>

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	<p>in the mornings and have to book more expensive later flight times. Food is also expensive because if you have difficulty with cooking you tend to order takeaway or more expensive pre prepared.</p> <p>4) I dont see any disadvantage with 2 rates for Mobility, currently thats the way it stads anyway.</p> <p>With regards to personal care, there is currently 3 rates low middle and high. If it is intended to change this to 2 rates low and high then what i feel is going to be necessary is that the person making the claim will actually have to cost out their care needs to see which category they fall into. At present there are lots of combinations for consideration help for an hour, frequent throughout the day, day and night, cooking only. Currently it appears to be quafified by time, and I for one feel there are lots of help I receive that cant be quanified simply by time.</p> <p>5) I am really torn 2 ways with this question and i will address it in relation to a physical disability. My heart is telling me that people who are paralysed for instance should automatically be awarded DLA both rates (High). It is obvious that they will have the highest reasons for both care and mobility needs.</p> <p>But, also I feel that people who have been diagnosed with Longterm Painfull conditions, such as Arthritis, Fibromyalgia, should also be considered here. And my reason for this is, constant pain and its impact can wreck your life. Even though your restrictions may not be as severe as a person who is paralysed and most people are at least able to try and manage their conditions the fact still remains that they are having to live on a daily basis in pain which can range from severe to mild and it impacts greatly on their mental state thus having 2 situations to deal with.</p> <p>However, I believe that the later is a situation where care needs and mobility problems could be proerly costed to establish which category each individual would fit into if any.</p> <p>6) I think the only way to get the answer to the first part of the question is to ask the person with the disability or if necessary ask their main carer. This is a question that I feel should be included on the DLA form itself from the outset. The person can then simply advise, by writing in their own words what they feel would help them to become more independent to assist them in living a full and active life.</p> <p>I also feel that consideration should be given to those who with help and support can work, but also equally to those who with help and support still may not be able to committ to work, but with help and support given can sucessfully manage within their own homes, allowing them to contribute to housework, raring their children, taking part in interests etc. From my own perspective, what is essential is a sense of self worth, a sense of achievement. Setting myself tasks and accomplishing these.</p> <p>I worked for 20 years, full time employment during the day, part/time youth leader at night 2 nights a week and one night voluntary, and at the weekends taking kids to cross community workcamps. I led a full and active life which I loved. It was devastating to have this all taken away because of something I had no control over.</p> <p>I still need to live a full and active life, that desire hasnt changed although it took a number of years mentally for me to be able to accept what I can manage now, so I have had to look at my life as it is now, decide how I am going to make that full and active. With disability, all the things that you could have done in the blink of and eye or without a second thought are no longer possible, not always impossible just not possible in the way you used to do them. My support came initially from my family, my GP, secondary medical care.</p> <p>All of the above and my own willingness give me the kickstart I needed. I continue to recieve support from my family and my GP when necessary.</p> <p>7) Some people have conditions that fluctuate and vary over a week, some over a month, some over several months. Others have fluctuating and variable conditions that fluctuate and vary each day and that is the category I fall into.</p> <p>Also, some people suffer from additional or a combination fluctuating and variable conditions, I also fall into this category.</p> <p>Again, i believe that this is a direct question that should be included at the start of the DLA form. In fact, I would go as far as to say there should be a seperate DLA form for these types of conditions and it could include both physical and mental disabilities.</p> <p>Establishing the frequency of the variations, fluctuations properly at the start would be essential in trying to determine what category of entitlement the person falls into.</p> <p>I also believe that people with these conditions should have to supply a diary record detailing their care and mobility needs over a period of time.</p> <p>8) I personally have never had an occupaional health assessment for aids and adaptations.</p>

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	<p>There are a number of aids I have purchased to make things easier and we have made adaptations within our own home using our own finances.</p> <p>I was always used paying my way and because I was I still continue to just take the approach if i need it and can afford it I will buy it. There are a number of other things already in my home that were not actually put there to help with my proplems but I have found them useful as a means of help.</p> <p>I believe that if an aid or an adaptation gives the person the help and independance they need to perform a task at all times then this should take away the necessity for them to claim DLA for that particular task. I think this should be applied to all tasks. If the aid helps only sometimes then only the times when it dosent help should be considered. If it is felt that the aid would be of no help then the aid should not be given.</p> <p>So, I feel it would be beneficial for all DLA claimants to have an occupational health assessment as part of their claim. It may not be necessary for all to have someone to call because if all the information is included then an occupational therapist who could look at the claim first can establish right away if there are possibilites that an aid or an adaptation would help and solve the problem.</p> <p>Recommendations could then be made to the Decision Maker and if a visit from an occupational therapist is needed, one should be arranged.</p> <p>The approach may entail additional expense, but it could possibly cut down on the number of EMP visits which in my opinion, based on experience are a complete waste to the public purse, especially for people with fluctuating and variable conditions. An occupational health assessor is way more beneficial than an EMP.</p>
ONLINE286	<p>1) This is a difficult question to answer as there are many types of disability and the problems and barriers vary enormously, not just between types of disability but also between how different cases of a disability present in each individual sufferer. While accessibility and medical needs may present the majority of issues for people with the more widely recognised disabilities, such as mobility problems or grand mal epilepsy, people with the more "hidden" disabilities, such as mental health issues, learning disabilities, behavioural disorders and autistic spectrum disorders, have a different range of challenges to overcome. It is imperative that any reform takes ALL the different issues into account! As the mother of an autistic child I can only comment specifically on the challenges he faces. Unpredictable behaviour and inability to control aggressive outbursts means that many things need to be regularly replaced. Sensory integration issues means that some sounds, smells and sights in everyday life are painful and distressing for him and he requires support to deal with them. Communication issues means he requires support in his interactions with others. sleep issues means that he requires support throughout the night.</p> <p>Lack of public awareness of Autistic Spectrum disorders means that quite often Autistic behaviours and mannerisms are misunderstood which leaves sufferers vulnerable to unwitting discrimination and persecution, often in situations they're unable to understand or deal with adequately.</p> <p>2) In my honest opinion, Everything!</p> <p>With the possible exception of the punishments incurred for fraudulent claims and falsified medical testimony.</p> <p>The problem with DLA isn't how it's implemented. The problem is the amount of people claiming it who shouldn't be. If people knew that false claims or medical testimony would land them in jail rather than a benefit suspension or fine, then less people would be willing to risk it.</p> <p>3) Again, this varies from case to case. I would imagine that care needs would be the main costs but it's impossible to narrow it down any further than that as every situation is different.</p> <p>4) I think this is a bad idea. The reason there is three rates for the care component is because of the variety in different cases needs. To remove one of those rates means that some of the people receiving it are pushed into different categories leaving them either with too much money or not enough.</p> <p>5) Any diagnosis that means the individual will require higher than average support should be an automatic entitlement. Of course, the rate of payment should still be based on the specific needs and circumstances of the case.</p> <p>6) This question is self contradictory! If an individual is going to lead a full and active life then the activities that are most essential is whatever they wish to do. If you are only accounting for activities essential to everyday life then the individual isn't leading a full and</p>

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	<p>active life.</p> <p>7) Make sure all medical assessments are carried out by people who specialise in the medical condition being assessed.</p> <p>8) It is fair to take into account any aids or adaptations they already own and use, If you wish to include others they may be eligible for you should include a bonus payment to cover the costs of obtaining them.</p> <p>9) You can't make the form more positive to fill in, if people focus on the positives then you won't get all the information needed to assess their needs. It's unfortunate but necessary!</p> <p>10) Any professionals dealing with the individual on a regular basis (medical, social worker, educational) and information provided by themselves or their carers.</p> <p>11) If the healthcare professional is a specialist in the disability being discussed then this is a good idea as long as individuals retain the right for the meeting to be held in a location of their choosing. However, if the healthcare professional doesn't understand the condition then it won't work, So it has to be a specialist.</p> <p>13) You expect people with learning disabilities, mental health issues and communication disorders to be able to identify and report changes accurately? I think, if you are reviewing cases on a regular basis then any sanctions incurred should only take effect if the individual had the opportunity to report it at a review and failed to do so. anything else risks persecuting individuals for something caused by their disability, which is discriminatory and deeply unfair.</p> <p>?) I'm confused by what you mean in this question, do you mean a one off bonus payment to cover the cost of aids or adaptations on top of the regular payments, similar to the social fund grants? If so I think this is a good idea as long as it covers the full cost.</p> <p>Currently, there are several different places which people can apply to for such funding but it means filling out information several times over. If this took the place of that I see it making it easier for people to access the help the need.</p> <p>?) once a child starts school, their care needs don't tend to change much until they reach adolescence, over-reviewing in these circumstances is neither cost effective nor beneficial. In fact, I would go as far as to say it would be causing unnecessary distress to families who are already in difficult circumstances.</p> <p>However, children's claims are usually managed by parents or carers so there would be no need to protect the from discrimination in regards to reporting changes.</p>
ONLINE287	<p>2) The ability to obtain a car via motability is paramount to a disabled person. This should not change.</p> <p>5) I strongly believe that if a disabled person has been examined in the past and is suffering from a degenerative condition/disease that these people should not require a further examination.</p>
ONLINE288	<p>1) Over the past 30 years, physical access has improved but from a low standard. Flat access to buildings often involves longer routes. Public transport is still a challenge as many stations are not accessible, have unreliable lifts and not enough or inadequately train staff. Not enough notice of platform changes are given. Most of the tube system in London is not accessible and while buses are, this makes travelling time consuming. Not only the journey itself but extra planning is involved before making such journey. There is now a lot more red tape and fill in forms is often difficult for physically impaired people and impossible for mentally impaired people. Businesses etc are required to make reasonable adjustments for disabled people and many do. But when things go wrong and it does, it is difficult and time consuming to get redress.</p> <p>2) Access to rail-card, blue badge etc</p> <p>3) This obviously varies from person to person. In my case (with a moderate disability!)  *Time €" everything takes longer. If you want any help due to your disability, you usually have to fill in a form!  *Need for a computer and a special mouse as writing is impractical  *Automatic car (usually the only choice is the top of the range)  *Tri-walker - NHS said I should get one but didn't help me do so  *Leg support €" initially supplied by NHS but even though it is falling to bits the only way I could get a new one was by buying it myself (easier than fighting the system)  *Phone calls €" ringing call centres takes longer etc due to my speech impediment.  *Difficult to get quotes etc due to problems of contacting people on the phone (most don't respond to emails)</p>

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	<p>*Shoes €“ I wear out 4 to 6 good pairs a year</p> <p>*Clothes wear out quickly and need more washing. I cannot repair them myself</p> <p>*Food €“ If no-one is available to help me, cooking is almost impossible, so I have to eat out or have take-aways</p> <p>*Housing €“ I have a bungalow though require no other adaptations</p> <p>*DIY €“ can't do even simple things like change a bulb myself</p> <p>So communication/obtaining information is area that has costs for many disabled people. Not just mobility and care costs.</p> <p>4) Unfair if people have a level of disability which means they just miss out on both components. IE they have both mobility and care issues but both are neither are sufficiently great to qualify for either allowance.</p> <p>Also the paper claims that DLA is failing because it does not represent individual needs and yet a far more inflexible system is proposed that fits people into very rigid boxes.</p> <p>5) Either approach will be unfair on someone. Some people's ability to cope with disability is greater than others. All such people should have the extra cost of their disability recognised.</p> <p>7) With difficulties. Even conditions that are static can affect people's health in other ways as they get older. Equally, people may have different abilities in different situations. These problems are magnified for people with fluctuating conditions. So criteria needs to be reasonable and flexible.</p> <p>8) If they are, you need to take into account both the initial costs, maintenance costs, replacement costs and the implications of breakdowns. For example, if an electric wheelchair breaks down while out and about. Most aids and adaptations have drawbacks. For example, extra wear and tear on arms, if using a walking aid.</p> <p>While in theory some aids and adaptations are available via the NHS or local authorities, in practice, it takes so much effort to obtain them, that in practice I use my DLA to buy what I need. I think this situation will get worse with the cut-backs. I have never found things easy to obtain.</p> <p>9) From my experience some healthcare professionals are not good at knowing what it is likely to live with a disability. The good ones, of which there are many, acknowledge this. If such people are used they should be experienced in what it is like living with a long-term disability €“ either by working in the care sector (not just hospital based) and/or by training that includes having to cope with limitations. For example, trying to do their job using a wheelchair for a week.</p> <p>If a claim form is to be used, it needs to be flexible and easy to fill in. And the options for supplying the information should be flexible e.g. paper or internet or phone or providing help for someone else to fill the form in for you.</p> <p>10) To appreciate someone's ability/problem areas you need to spend time with people in their day-to-day tasks. But this would be impractical. For many people, GPs are best placed to know their patients ability. However some impairments restrict people's functioning but do not require medical intervention.</p> <p>11) It will avoid the problem of form filling but many healthcare professionals do not know what how disabled people function in a non medical environment! Some people would actually appear more disabled than they are in their ordinary environment. Equally, people with fluctuating conditions may appear more able than they usually are.</p> <p>12) This should depend on people's situation. Frequent reviews may discourage people from improving their situation (if possible). What is the point of having reviews for people who were diagnosed with a permanent impairment from birth, beside causing distress and costing money?</p> <p>13) By making it simple!!</p> <p>14) Exactly what is involved and where people can go for independent advice. This is particularly important for people with a new impairment.</p> <p>15) Advice and support is very difficult to access with the need to get referrals etc. If this becomes a requirement, you would need to improve these services considerably and in practice this would increase the costs of providing disability benefits.</p> <p>16) Yes, many people fund aids and adaptations through DLA. It would make life complicated to have to make one of claims, particular for small frequent costs e.g. shoes and clothes. For bigger purchases it may be more practical but there can be disagreements about when items need replacing.</p> <p>?) I did not see much mention of age. People who have been disabled for many years and particularly since childhood were often not given the same opportunities as their able-</p>

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	<p>bodied counterparts. Poor education etc. adversely affects people's life chances in many ways. People who have become impaired later on in life are less likely to have faced these further disadvantages.</p> <p>?) I use my entitlement to get a rail card and a blue badge. It is a nuisance having to fill in a written form to obtain a blue badge so something could be done about this system – an online application would help. I appreciate why badges need to be renewed but the system is awkward.</p> <p>Sometimes other organisations ask whether I am registered disabled and want documentary evidence. I have had to get letters from my GP to prove the blinding obvious. My GP could charge me for this (but hasn't so far). Perhaps a clear multi-purpose proof of disability could be created – not necessarily related to Personal Independence Payment. Many organisations asked if you are registered disabled but even they do not know what this means!</p> <p>?) More form filling and more time wasted getting documentary evidence to prove what (in my particular case) is blindingly obvious.</p> <p>?) Some sort of passporting system. Access to this by organisation other than the benefits agency should be under the control of the person.</p> <p>?) This paper rightly stresses the importance of the social model of disability and the improvements that have been made and that benefits should help people function in society. It recognises that people's individual needs differ, yet PIP is based on the same components as DLA but with few options. Before this paper was written the government said they wanted to reduce spending in this area. So the real agenda is to cut spending. It is probably true that individuals claim a DLA they are not entitled to, yet it is equally true that people who would be eligible for DLA do not claim. So without research, it is not possible to say a new benefit will better target people and save money!</p>
ONLINE289	<p>3) Heating costs, Travel costs for hospital or doctors appointments, also extra costs to pay for help around the home and garden</p> <p>4) The middle rate for both components should stay as disabilities have such a wide range of difficulties that two levels would not cover them fairly</p> <p>8) no they should not. why should the disabled person be penalised for making a difficult life easier.</p> <p>10) The disabled person is best placed to tell how disability affects them and their doctors to confirm their account</p>
ONLINE290	<p>1) Test response</p>
ONLINE291	<p>1) Main problem is people's lack of understanding the full issues using medical models not the social models needed, transport is still a main issue for most disabled people, we have what is accessible transport, yet disabled cannot use it as when they try to board a bus the designated area is full of child buggies and shopping trolleys, or access to the bus stops train station blocked by parked cars on the pavements. It's the abuse of the systems in place that cause the biggest barriers for the disabled person.</p> <p>2) once more we see the age barrier being waved like a red flag, a person's disability does not disappear with age, in some cases age related problems increase the need for the DLA benefit received. DLA should stay the same for all ages, with no constraints as to how to spend the DLA benefit, freedom of choice and flexibility of purchase over enablers or domestic assistance, mobility the choice to use private car purchase or the mobility hire/purchase scheme.</p> <p>3) this is a very broad subject, each disabled person's needs vary from person to person, they will vary from personal assistants/enablers to aids to assist with every day living e.g specialised equipment like wheelchairs both electric and manual, adapted cooking utensils, communication/walking aids (deaf blind), clothing, enablers and domestic assistants to help with every day living, specialised transport needs and adaptations, dietary cost, heating (for the less mobile) adapted leisure activities, specialised housing needs, most important the disabled person's quality of life has to be maintained</p> <p>4) having two rates will make the administration easier, but what safety nets will there be in place for the people who do not fit exactly into the new system, will they be excluded or will it increase the appeal process, what happens to the disabled person who is an active disabled person, will they be penalised for looking after their health and keeping fit, will the new system encourage people not to look after themselves thus creating more medical problems, this could spiral out of control thus causing more administration work and an</p>

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	<p>unfair system will evolve.</p> <p>5) to be fair all applicants should go through the same process for entitlement, but there are very exceptional cases where automatic entitlement may be needed with a review after 6 months, this is only to ease the stress on a person if the prognosis is terminal or critical.</p> <p>6) people who are least able to lead a full and active life still need a quality of life to enable them to enjoy what little activities they do, these people will need more help than an active disabled person due to the constraints placed on them by their disability. their needs may be personal care, domestic care and assistance with travel.</p> <p>7) the only way is to set up a monitoring system that will review the applicant after 6 months to a year to assess their needs over that period, then make the final adjustments to their package of payments.</p> <p>8) all aids and adaptations should be taken into account, not only useage but also replacement costs of the item's if they are not covered by social care packages due to the recent cutbacks, due to these cutbacks disabled people are having to purchase more aids and equipment themselves. e.g replacement wheelchairs, cooking aids, bathroomand/toilet aids, communications aids, adapted vehicles, dental treatment as due to cut backs the treatment has now been cut to basic minimum dental care for people on benefits, future needs also have to be taken into account if the disabled person has a degenerative condition.</p> <p>9) make it easier buy not asking double edged questions or asking the same question twice further on in the form. use plain English at all times, make a clear mission statement at the begining as to what/who the benefit is for, advise people where to go for more clarification on eligibility and borderline cases.</p> <p>10) while we need to keep the social model in perspective there is an obvious need for medical assessment and evidence on the persons condition, e.g length of disability, what type of disability, treatments received/proposed outcome of treatments, medication,are they smokers or obese thus agrevation conditions, aids or adaptations provided by the NHS or Social Services. Independant review panal with both medical, social and peer group representation.</p> <p>11) it may bring communication difficulties for people with severe learning difficulties/mental health issues or deaf blind applicants who need longer to understand the issues.</p> <p>Face to face would be inappropriate for people still in hospital, or where it might cause distress to the applicant e.g terminal illness.</p>
ONLINE292	<p>1) a major problem or barrier is the mobility of each individual particularly those who have mental incapacities who are unable to live at home and need to be cared for in residential homes. Many have underlying health issues or are disabled in such a way that they would be unable to leave the care home unless accompanied by a carer. This immediately doubles many public transport costs and can also incur a cost of paying the carer to accompany the individual. Removing the mobility aspect because they are in a residential home will restrict their ability to leave the residential care home and will render them virtually equivilant to a detainee - imprisoned is their care home.</p> <p>2) The mobility aspect is planned to be removed for those in a residential care home on a permanent basis. This would restrict those capable of having trips out for shopping, leisure etc from doing so and render them 'prisoners' in their homes. Whilst there are savings to be made in this area each case should be dealt with on an individual basis, mobility being assessed to the needs of each individual.</p> <p>3) Disabled persons often require additional costs with their mobility. A mentally handicapped person, needing a carer to accompany them anywhere outside their normal residence for example visitng doctor/dentist/hospital/shopping or whatever trip would need additional costs where public transport etc was to be used. Potential cost for the time of the carer over and above that already accounted for. Additional heating costs within residence</p> <p>5) some impairments will be life long and potentially lead to further deterioration and there maybe therefore be automatic entitlement following one initial assessment rather than repeat reassessments</p> <p>11) facilitatng meetings with several personnel often leads to problems with meetings being delayed or ultimately cancelled because one or more parties to the meeting fail to turn up. This is time consuming and frustrating especially where working family members are invited to intend and take time off work only for the time to have been wasted. Better</p>

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	<p>meeting management systems need to be put in place.</p> <p>12) Currently care managers are appointed to individuals and they call regular meetings to discuss the care of the individual. Whilst this can be a useful exercise. There are cases that there is no change or little change from one meeting to the next. Meetings in these cases should be kept to annual with additional meetings being called for by family members or care home if circumstances change between times.</p> <p>13) some form of secure internet log system, accessible in one place that is then able to flag up needs/comments/requests and direct them to the appropriate best provider to resolve the cases.</p> <p>?) currently a very disjointed service - this needs to be more integrated.</p> <p>?) one-off costs would be useful as additions to the regular payments</p>
ONLINE293	<p>1) There are lack of resources and care that prevent disabled people participating in society, people have to fit into the care that is available, if any. Even with the help of DLA payments, this does not cover the costs of people who require enough care to support peoples needs and local authorities aren't helping meet the needs. People are getting told take this or get nothing. Sometimes this is help that the disabled person cannot access. This leaving people ending up with more and more health problems and less and less abilities</p> <p>2) The amount of rate that is paid should not decrease, as in many true cases, the money doesn't cover the extra expense.</p> <p>3) paying for care and help to get everyday jobs done, ie. shopping housework, washing and ironing ect..., costs of aids to help make easy tasks able to acheive and without or little pain, covering expenses of people and workers who are helping you. mobility expenses such as transport, voluntary cars, buses and taxi's and people to help you go out.</p> <p>4) currently there are 2 different componants, and 2/3 rates, so there won't be much difference.</p> <p>5) should be looked at what a person can do taking into account that disabilities are changable due to weather enviornments and other conditions</p> <p>6) getting shopping, washing, ironing, clean enviornment, going out to socialise, using local facilites. personal care,accessing health appiontments,</p> <p>8) no</p>
ONLINE294	<p>1) The cost of being disabled from care, paying for 2 people when you are out or away, equipment to make life easier and more enjoyable eg an electric wheelchair, which if you can push so many meters on a smooth surface, you are not entitled to. I live on a farm and the difference it makes is beyond calculating. The cost of heating, no heating allowance for under 60 or 65 not sure which. I have been a paraplegic since I was 21 now over 25 years ago, and cannot function in the cold because of lack of circulation. The dla mobility covers part of my petrol, because I have to use my car to go out anywhere because I cannot get in and out of other people's cars or most public transport where we live. The cost of petrol has gone up far more steeply than the allowance.</p> <p>As I get older it is becoming increasingly more difficult to get out and about. My parents gave me a large amount of support, they are both now in their 70's and not able. My friends are older and have their own families and commitments.</p> <p>The council used to be very supportive, and my personal care was provided at minimal cost. This has completely changed in the last few years, and what savings I had are dwindling that were there to ensure I could live independently in my own home and pay for such things as heating, food etc.</p> <p>I look at a future where I may have to leave the house I live in, but don't own because I cannot afford to live here and be totally reliant on the state for housing.</p> <p>It is impossible for people who are disabled from a young or early age to plan for a life of care and dependency and impossible to save and improve the quality of life if as soon as you earn and have any savings you have to start paying for care.</p> <p>As a disabled person I feel the future is bleak, and I don't believe in the Right to Die Bills that keep cropping up, but I fear that if the disabled and the elderly keep being treated as they currently are, that people will feel that this is an option and road they would take, rather than a long and dismal road of dependency and lack of quality of life.</p>
ONLINE295	<p>7) I am sure the majority of DLA customers are honest, however there are a significant proportion who are not and I think the only way that a large portion of the 'dishonest' element will ever be routed out is by making all working age 'disabled' people sign on for Employment Service Allowance (except terminally ill cases). This way a regular</p>

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	<p>assessment can be conducted with a view to helping that person back into an independent and gainfully employed life instead of being abandoned to a life on DLA benefits.</p> <p>13) As a DLA Fraud Investigator I see examples on a daily basis of where customers have failed to declare a change in circumstances to DLA despite obvious improvements in health and mobility. I think the only way to discourage this practice is to invest more in publicity (as in the DWP 'Spotlight on fraud' TV advertisement campaigns) aimed at changing attitudes to DLA fraud. At the same time increasing the fraud detection asset. Together this will act as a strong deterrent to people who think its ok to pretend to be disabled for monetary gain and at the same time encouraging people to notify a change in circumstances.</p>
ONLINE296	<p>1) To many people use the DLA as an income and not towards thier care. There is a fear of loosing the income if they work</p> <p>2) access to mobility, aids and adaptions are essential. Yes it would be helpful to provide the information as part of the claiming process.</p> <p>3) mobility, aids and adaptions and accessing personal care, support. Absolutely. there may only be a one off cost with no further requirement from benefits</p> <p>4) I do not believe is it is essential to have 2 rates per component. If peole are assessed appropriately they will recieve and amount according to need and not level. have 2 rates may cause people to feel they are loosing out on benefits and not clearly identify that it is needs led.</p> <p>5) I believe all health conditions should be based on need. Although I do believe there should be a fast track system in place for certain conditions and deterioration in circumstances.</p> <p>6) key professional people involved with the individuals care should be in a position to identify priority. I believe there would be a training need involved but professionals should be accountable for the reports they are providing for the person. Devolving the budget to key professionals may make professionals think about who they are supporting and who would be prioritised.</p> <p>7) A review mechanism should be automatically inbuilt to allocated DLA, dependant on conditions. Questions should be geared around fluctation and frequency of symptoms use of diaries or recordings of peoples conditions over a period of 6 months.</p> <p>8) All aids and adaptions should be included. Aids and adaptions are available to assist people with thier conditions and therefor all should be taken into account.</p> <p>?) The use of a single shared assessment where all professionals add their information and assessments</p> <p>9) allow for variations in people conditions. People have coping strategies in place to help them but they do not always identify them. Reading material needs to be clear and consise.</p> <p>10) The person them selves, GP and specialist workers in the field of the conditions being reported. Evidence of the work, treatments, aids and adaptions being used. summary assessments from the key individuals involved</p> <p>11) People on DLA do not like being told that the healthcare professional will not support thier application and can cause problems with the working relationship. On the positive professionals need to be honest and stop supporting applications they do not believe in. It will make the professionals accountable for thier reports and recommendations.</p> <p>12) I believe that all initial reviews should be done between 3 and 6 months of recieving the DLA. It should be 6 monthly to 1 year reviews there after dependant on the condition. Only conditions that are terminal or degenerative should be reviewed less frequently. Everyone else should be reviewed yearly wether directly or indirectly using key health professionals. People need to stop seeing this benefit as an ongoing right.</p> <p>?) The DLA is over due a review on who and how peole recieve the benefit. I believe too many people are in receipt of this benefit at a cost to the tax payers. Too many people are not using the DLA towards thier care needs but as an income. Substance misuse clients using their DLA money to feed their habit is a disgrace which many professionals are aware of but I am sure the general public are oblivious to but would be appalled if they only new. In my job trying to get people moved on through a recovery process is hindered by the fear of losing thier income. People choose to stay in a sick rle which is unacceptable and difficult to address.</p> <p>?) not sure</p>

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	<p>?) Long drawn out processes with lengthy delays in accessing other services</p> <p>?) My experience is that DLA does not assist in accessing other services or entitlements. Yes by looking at a system which talks with other systems.</p> <p>?) Not sure</p> <p>?) Either by themselves or through health and social services.</p> <p>?) I think there should be a requirement for advice and support as that would enforce a conversation around what is being supported and what's not. Key features is that the person needs to have a healthcare professional support their application.</p> <p>?) They will want to know what is expected from them and others involved with their care.</p> <p>?) Ensure that health professionals are tasked with the responsibility to inform you of any changes. Bring in line with other benefit frauds.</p>
ONLINE297	<p>1) Lack of funding for support services, lack of funding for adaptations. Lack of suitable housing. Lack of support for society - unwillingness to bear the expense of making society accessible. Lack of understanding of people's needs. Lack of understanding of people's abilities and wishes.</p> <p>2) Different levels of benefit recognises that not everyone's level of need is the same. People with higher levels of need require higher levels of support.</p> <p>3) Paying for care services. Paying for equipment and adaptations. Additional heating requirements for people who are less mobile or whose condition impairs their ability to regulate their own temperature. People with Huntington's disease often have additional food, clothing, furniture and bedding costs because of the nature of the condition. Many disabled people have additional transport costs - taxis if public transport is not accessible. Many disabled people have to pay people to do things for them that everyone else is able to do themselves - housework, shopping, gardening, packing to move house, moving furniture within a house.</p> <p>5) Yes. Off the top of my head I would suggest motor neurone disease, Huntington's disease, registered blindness or partial sight, deafness, some forms of multiple sclerosis, Parkinson's disease, amputation or congenital absence of two or more limbs.</p> <p>6) The most essential activities are  breathing  eating &amp; drinking - swallowing  elimination  communication  movement &amp; mobility  self care - washing, dressing, grooming, maintenance of personal hygiene, skin cleanliness etc  then things like social interaction, work, leisure, domestic tasks</p> <p>7) Have a proper understanding of the reality of variable and fluctuating conditions. Understand and accept the reality of life for people whose abilities change, and the context in which they are living - unsympathetic employers etc. Ensure that assessments are carried out by people who know and understand function - occupational therapists and physiotherapists.</p> <p>8) Aids and adaptations assessed for by a trained professional should be taken into account. For example, anyone can buy a mobility scooter but that doesn't mean they actually need it. Adaptations a person doesn't have should not be considered, unless they have been offered it and refused it. It is unfair to refuse benefit on the grounds that someone should have a particular adaptation if their local authority has refused to provide it because they are assessed as not meeting the relevant criteria or because they have inadequate funding.</p> <p>It should be noted that provision of a suitable piece of equipment, such as a wheelchair, does not necessarily mean that a person still has no difficulties getting around. They could still have additional transport costs if public transport is inaccessible to them. They might still require an assistant with them if they are unable to operate their wheelchair independently, or if they want to go shopping and can't reach items. The assessment should take into account the society the person lives in and the activities they want to do.</p> <p>10) Occupational therapy reports from the relevant social work department. Information from the GP and other involved health professionals - physio, district nurse, speech and language therapist. Social work input.</p> <p>12) The medical diagnosis should inform the decisions about how frequently to review. Slowly progressing conditions should be reviewed less frequently, things like motor neurone disease more often. Review of people with relapsing remitting conditions should</p>

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	<p>take into account that someone might have improved in the 6 months or a year since the previous review but might relapse again the day after.</p> <p>13) Write to them every six months or year and remind them.</p> <p>16) Depends on where they live. Most local authorities do not charge for equipment or minor adaptations, but some do. Major adaptations are grant funded and the grant is means tested so people not in receipt of qualifying benefit have to contribute to the cost. Is it reasonable to expect someone to use their personal independent payment to pay for an adaptation if it has already been taken into account when assessing whether they have to pay for their care package? If the personal independence payment is used for a one-off cost, would it be withdrawn for the future? If so, how do people pay for their care? If not, why have means testing of grants at all? Why not just increase funding to local authorities so that major adaptations are fully funded?</p> <p>? ) I'm not clear what you mean by this. Do you mean that people who receive PIP would therefore not be eligible for other benefits and services which DLA currently entitles them to, or do you mean that people who receive PIP might be entitled to the other benefits and services but would have to undergo another application and assessment for each? The former is ridiculous. The latter would mean more time, effort and cost for service user and service provider to complete and process applications.</p> <p>? ) Social work and occupational therapy assessments completed within local authorities should be shared with DWP to assist claims for PIP. Local authorities have a duty to assess people with disabilities so would be unlikely to accept a DWP assessment for PIP as evidence for entitlement to services.</p>
ONLINE298	<p>1) FOR HOSPITALS TO INFORM US OF ANY ADMISSIONS IF THE CUST IS ON BENEFIT. PEOPLE ARE AWRE WE HAVE NO WAY OF CHECKING ON THEM.</p> <p>2) NEVER BEEN ON BENEFIT ???</p>
ONLINE299	<p>1) The barriers for disabled people are societal, in terms of access, provision of services and so on, but also there are challenges relating to the reality of our impairments. I think the challenge of managing ones energy is huge and this benefit is particularly valuable in that regard; access to ready prepared ingredients, taxis as well as human support is essential in maintaining independence.</p> <p>2) I do not understand the idea of reassessing those who are on the highest rate who have an unmistakably permanent or progressive diagnosis. It seems a poor use of resources and an unnecessary burden on the disabled person.</p> <p>3) Extra costs; travel, heating, increased wear and tear on clothes, mobility equipment, extra kitchen equipment which is easier to use, increased breakages, increased buying of domestic entertainment - books/dvds due to increased time sick, part ready food and cooking ingredients. Travel - taxis, buses, extra journeys. Help in the house and garden. For me, extra costs in working, needing all the above in order to keep working. If you are not able to walk; whatever other means used has a cost. Equipment is not funded in any other way, thus DLA is essential. I used my DLA to fund my £10,000 wheelchair without which I would be in bed all day, and thus not working and participating in the community.</p> <p>4) This change appears largely administrative. The key issue is having enough money. I presume that this is to reduce the cost of this invaluable benefit.</p> <p>5) I think everyone should have to go through an assessment of some sort, but perhaps that can be varied. I do believe that for certain conditions that once awarded the award should be permanent.</p> <p>6) All of them! Getting around, interacting with others, managing personal care and treatment, accessing food and drink, travelling and communicating with others. Being able to keep your house clean is essential also as is being able to work!</p> <p>7) By awarding for the worst symptoms, so the person can make the most of the better times they have.</p> <p>8) Aids and adaptations should not be taken into account. The more aids and adaptations the person needs, the more difficult their lives are. Taking aids and adaptations into consideration will have a negative impact on disabled people.</p> <p>9) Making it shorter, and clearer</p> <p>? ) For me, very little. It may have value for those claiming Universal Credit</p> <p>? ) You would need to avoid financial penalties, and to find ways to engage people and motivate them while reassuring people they will keep their PIP. Many disabled people are very poor and the fear of being poorer may stop them trying to improve their skills and so</p>

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	<p>on,</p> <p>?) By making clear what will happen when their circumstances change, and making the changes which occur when they report a change fair.</p> <p>?) This is essential. Please keep this feature.</p> <p>?) Clear timeline, transparent policies, and good examples of how it can be used.</p> <p>?) It would be very negative, as would increase the time the disabled person would need for administering their lives, and detract from their ability to participate.</p> <p>?) Most disabled people already do this! Any fewer sources of financial support for aids and adaptations would be a disaster. Using PIP to part fund wheelchairs is reasonable but other aids and adaptations should be funded elsewhere.</p> <p>?) Yes - make them clearer and better known.</p> <p>7) If this was not a passport this would mean additional admin for disabled people, disabled people needing to spend their PIP on doing so, and all this reducing the disabled persons ability to work.</p>
ONLINE300	<p>10) Please consider carefully who is best placed to assess social and emotional disability. My twins with severe attachment disorder can appear absolutely fine (perhaps even charming) to a new adult for a considerable length of time. This is part of their disability - taking care to hide their fear and please the adult who they perceive as threatening. They may also suggest it is their mother who has the problem and not them. This has happened repeatedly for us and yet my twins have such severe disability that they have a bespoke education package funded by the local authority in lieu of a residential specialist EBD school. However I (their mother) would happily spend time face to face with an assessor rather than spending hours filling out the form...</p> <p>11) we adopted two children with severe social and emotional difficulties. It would have been very inappropriate to require a face to face meeting with them as this would have caused considerable distress and anxiety. Also they have attachment disorder which is not easily assessed by direct observation.</p>
ONLINE301	<p>1) Attitudes towards disabled people have not changed significantly through the introduction of the Equality Act or Disability Discrimination Act. Disabled children are still segregated from non disabled children through the schooling system. Expectations towards disabled children are low. The attitude that work is the only way you can contribute to society compounds the low self esteem felt by many disabled people. The majority of employers still believe that having a disabled person work for them will be an additional barrier. Variable conditions are not recognised by employers or society at large and are not taken into account through the benefits system. Disabled people face extra costs whether they live independantly or not. In addition to this there is a misconception of what independant living means, forcing disabled people into isolation.</p> <p>2) DLA is a passport to other benefits and this is of crucial importance and should say the same. Currently it is intended to take into account that if you qualify for DLA you also have higher costs in general and this should continue to be topped up.</p> <p>4) A large number of disabled people benefit from having a small amount of money each week which helps them to meet extra costs. This lower rate is specifically targeted at people who find it difficult to carry out activities such as cooking and keeping their house hygenic. I am greatly concerned that these proposals may take away independence brought about by this small amount of money for people with variable conditions which are not currently understood or taken into account. Therefore, simplyfing the benefit to make two levels of the care component rather than three is likely to tip many disabled people with variable conditions into poverty.</p> <p>5) Some inpairments mean that you are unable to do certain things which have an impact on your day to day life and mean that you face higher costs. I therefore think that some impairments should automatically entitle you to a particular rate. Currently there is problems with the system relating to variable conditions. I believe that it would be more profitable for the government to focus resources on training health care professionals to understand variable conditions better and ensuring that DLA assessors and decision makers have areas of expertise, in particular varying conditions. This would cut down costs as it would more accurately reflect the problems faced by a majority of disabled people and cut down on the number of tribunals which are taken, investing in a thorough understanding of the complexity of impairments would be much more effective than taking away automatic entitlements which in fact would increase costs.</p> <p>8) Aids and adaptations are essential to a disabled person being able to live, not only live</p>

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	independantly. The use of aids and adaptations does not eliminate attitudinal barriers, physical access barriers or the struggle that disabled people may have in carrying out activities. I am therefore very concerned that aids and adaptations not be taken into account. If this happens it will also discourage disabled people from accessing aids and adaptations which they need to survive, not just to carry out every day activities.
ONLINE302	<p>1) people understanding the needs of disability and acceptance by others and support. Daily and very 'normal' tasks are very much more complicated, time consuming and take more energy, thought and planning. Travel &amp; going out to activities is one of the big issues, often it is easier just to stay at home and not go out. I am the carer for a autistic child with learning difficulties behavioural issues &amp; language disorder. When I take her anywhere I have to consider, how we will get there, where will I park if I go by car, if I can get another adult to go with us to help. what will be at the event, will people understand if we have to leave early, or indeed as soon as we arrive? if we have to sit in the corner &amp; not participate at all. When ever we do anything its not straight forward, anything that helps us is genuinely appreciated. A car &amp; blue badge makes us able to go out &amp; do more things, it helps us live fuller &amp; more active lives.</p>
ONLINE303	<p>1) I still think peoples attitudes towards disability is still one of the major stumbling blocks. For myself suffering from poly osteo arthritis it is access to Consultant rheumatoid specialists - it is called "wear and tear" and dismissed. I was seeing a pain specialist who I pressed to see, and who I only knew existed because I used to work with her, after having several pain relief injections under sedation she asked my GP to refer me to an Orthopaedic Consultant. Unfortunately for me my PCT has run out of money and the GP's have been told only urgent referrals can be sent, so I stay in constant pain, and I am not the only one. It makes me feel isolated and now I feel everyone is watching me to see if I am as ill as I say, it is very stressful dealing with constant pain and worry.</p> <p>2) Personally I was awarded DLA indefinitely following GP, Consultants and an NHS Occupational Consultant who finished my career in the NHS after 30 years gave their opinions on my health. I have been working since I left school, I brought up my daughter for 10 years alone, when I was training for my career and I have never signed on for unemployment. Even when I was told I would receive more in benefits than my training wage. I could be earning a lot more money as a professional grade worker in the NHS, and I would if I could. I have x rays and scans that show my disease I cannot fake them - why should I have to attend back to work interviews and basic maths and english tests, I passed with full marks by the way, fill in numerous booklets of questions. All of this is money that can be saved if somebody who knew what evidence they were looking for assessed these cases.</p> <p>I know there is a problem with people that are getting money they are not entitled to but surely there are people like myself who have contributed for a great many years who should be allowed to stay on this benefit that they are happy with without more bureaucratic meddling.</p> <p>Most of the people that have been awarded DLA indefinitely have been properly assessed it is wasteful to just retest everyone, it is stress that sick people can truly do without, do what you say "the right thing" and use some common sense and stop redoing things wasting time and money.. my money I still pay tax.</p> <p>4) People are more likely to be put in the lower group - I think that the top rate will only be for very severely disabled people and people who need extra help will not get it.</p> <p>8) Most disabled people who need aids are able to access them</p> <p>9) When I filled in my claim form and my renewal form I found it incredibly upsetting and negative. It was so long and so emotionally draining it took me several days to fill it in. I put things on that form that I have not even told my husband and a stranger was going to be reading it. It is actually upsetting me just thinking about it and I have to swallow any self respect I have and answer the most personal questions onto a piece of paper and send it off. I think that evidence from medical sources should be given more prominence.</p> <p>10) Supporting evidence should be from GP's who know the person and medical investigations that show the person is actually suffering from a condition with evidence to prove it- X rays ECG EEG Scans etc</p> <p>11) As I have said it is really difficult and upsetting to speak to a total stranger, who may have no medical training, about really personal things.</p> <p>12) If somebody has a medical condition that is never going to get any better or has no cure then they should not be submitted to several reviews it is unfair.</p>

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	<p>Of course there needs to be different reviews for different conditions</p> <p>13) I find my DLA very easy to understand.</p> <p>You will always get some people who will not inform you - the GP should be more involved regarding people who have conditions that may improve over time. If the GP had to reissue sick notes on these people on a 6 month or yearly basis he is in a better position to know how the person is affected by their condition</p>
ONLINE304	<p>11) Hi,</p> <p>It seems the assessment process you are planning to implement has a large number of links to the central ethos of Occupational Therapy, looking at each person as an individual and the activities they complete as part of their everyday life. As an Occupational Therapist with working experience in both community and health settings I am keen to know what role you see our profession taking in the assessment process and whether the assessment will be completed by a professional?</p>
ONLINE305	<p>1) One would expect that disabled people are more afraid of trying work because of employer prejudice towards their varying health and higher level of absenteeism through health related issues. On the other hand disabled people are more likely to feel more comfortable with trying self employment - starting their own business. The barrier there is funding and a suggestion would be give DLA claimants a full 12 months of their DLA award AND other benefits that they also get combined (which commonly is income support incapacity benefit, housing benefit and child tax credit in some cases - to enable them to start their business, with a 6 month protection on their benefits if their health does not stand up to self employment, after this 6 months they agree to sign off all benefits.</p>
ONLINE306	<p>1) There are a number of issues, which produce a toxic cocktail.</p> <p>Disabled people sometimes have reduced self-esteem and assume that they will be disadvantaged both in the workplace and in Society. This is not a financial problem but a Social one. Disabled people sometimes receive genuine prejudice from others in Society, some of whom perceive disabled people as scroungers, which is only made worse by the perception engendered by the Motability Scheme that the only person you know who can afford to drive a new car is a disabled person.</p> <p>In addition, there is a prevailing assumption in Society, which is reinforced by the Press that to have any kind of disadvantage is your own fault. In some cases, of course it is. The TV programme concerning the £100,000 per annum, which it costs to care for a 58 stone man is a good example of this. A similarly addicted alcoholic, anorexic, or drug-addict by contrast, receives little support. Being disabled is in the eyes of many people in Society a synonym for being over-weight.</p> <p>With all these attitudes prevalent in Society, how can a disabled person be fairly treated...and I have not begun to discuss the financial and physical barriers to leading a full, independent and active life.</p>
ONLINE307	<p>1) As a disabled person at only 31 and have been for the last 8 years, with severe arthritis in both my ankles, knees and hips, I find that my high rate mobility payment I receive means I am able to afford a car, which means that I am dependant, I work, I can go shopping, what I would do without this payment, I have no idea.</p> <p>I am not claiming benefits, sat at home, but without this benefit, I more than likely would be, as I have to have time off for physio, for injections, without this extra help, I would lose all independence, self worth and motivation</p> <p>2) All of it, I do realise there are people out there who are taking the mick and are fraudulently claiming and these are the people that need to be chased, but you are now persecuting the people who do really need and rely on this money.</p> <p>Not everyone who receives DLA are on Sickness benefit and to persecute disabled people who are working, I think this government wanted to keep people off benefits, not more people claiming them</p> <p>3) My extra costs are petrol as I cannot walk any form of distance unaided, the cost of running my car, MOT, Tyres, Servicing as I can do 5000 miles a month</p>
ONLINE308	<p>1) Problems and barriers include access to transport - not just the occasional accessible bus, but also the opportunity afforded by the wonderful and in my mind irreplaceable Motability Scheme to have an adapted car on contract hire. This offers huge opportunities for independence, employment, contributing to society and socialising - all of which able-bodied people take for granted.</p> <p>Changing needs of individuals' medical conditions - many disabling conditions (not just the obvious ones like MS and ME) affect wellbeing on a daily basis in different ways. My own</p>

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	<p>condition (spinal cord injury) increasingly affects my energy levels, and the overall health of my body through tiredness, muscle strain, bladder and bowel problems. There is not enough awareness of these changing needs, and an inflexibility about meeting them in the workplace.</p> <p>Prejudice and stereotypes - disabled people still face a lot of negative attitudes and assumptions, which can range from fear to pity to a belief that we are somehow not full human beings and will be a burden or drain on the employer rather than an asset. This is very deep-seated and needs tackling both legislatively and through education.</p> <p>Physical access - there are still far too many places which are not accessible to disabled people and too much emphasis on the individual disabled person having to initiate legal action rather than the onus being on the shop, employer, service-provider or whatever being expected to improve.</p> <p>2) I think it's absolutely vital that the Motability Scheme, which is accessed via entitlement to Higher Rate Mobility component, remains in place - I cannot over-estimate how vital this is to enabling independence, both socially and in enabling employment.</p> <p>I also think the Mobility component should continue to be provided to people in residential homes. I think it is not only mean to remove this entitlement (for a relatively tiny saving), but also fails to appreciate the nature of modern residential care living and would deny these individuals the right to things that others (including other disabled people) take for granted - the ability to go out when and where they want, on an independent and autonomous basis.</p> <p>3) The main extra costs:</p> <p>transport - without the Motability Scheme, transport costs would be massive - as a wheelchair-user with very limited range, I'd be dependent on taxis to take me everywhere (including out to work). The cost would be quite possibly prohibitive and might result in me not being able to go out to work (I'm a counsellor) which would have the knock-on effect of having to claim unemployment or other benefits, which would be an unintended consequence of the change, I'm sure.</p> <p>Heating - being less mobile, amongst other aspects of personal medical conditions, means that our houses need to be heated to a higher temperature than is common in order to keep us warm. This can be very expensive.</p> <p>Additional health/disability-related costs - incontinence supplies, painkillers, my regular prescription for anti-spasmodics etc (I'm not entitled to free prescriptions and even with the pre-payment certificate, my regular prescription costs amount to nearly £20 a time).</p> <p>5) I think all claims should be based on individual need rather than automatically on the basis of specific conditions, HOWEVER, the individual must genuinely be at the centre of the assessment. There must be a flexibility in the assessment to allow for the very different ways in which any particular condition can affect the individual. I have an acquaintance who has a very similar level of spinal cord injury to me, and we are of similar age, but we are affected very differently by our respective injuries. These variabilities MUST be genuinely reflected in the assessment process.</p> <p>6) I think it's vital to include 'quality of life' activities in the new assessments. For example, while the ability to have a night out at the cinema or down the pub is not 'essential' to life and limb, these activities turn life from 'existing' to 'living'. Their added value is that they help people feel better about themselves, their lives, and feel part of their friendship groups and communities. They are therefore less likely to become depressed, isolated and a drain on resources rather than a potential contributor (e.g through work or volunteering). Having choices is essential - do I choose to pay for a taxi or to put my cash towards a Motability car? Do I choose to stay in and cook or to pay for a takeaway or a meal out? Other essentials - autonomy. Being enabled to make independent decisions based on our assessment of what is best for us as individuals.</p> <p>Opportunities - to get a job, somewhere nice to live, to meet other people, to enjoy educational and socialising opportunities.</p> <p>7) This is where the assessment must have the individual at its heart. Although my condition could be assessed as stable (spinal cord injury), my experience is that as the years have gone by, it is increasingly affecting my ability to manage effectively because of increasing problems with shoulder strain/pain, continence problems, and overall energy levels. These can fluctuate enormously from day to day.</p> <p>I think the new assessment must allow for individuals to report on their 'best day' and 'worst day' abilities; if the assessment is done on a 'good day', then this could seriously exaggerate the person's abilities. Equally if it was done on a 'bad day', it could overlook</p>

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	<p>their ability to cope at other times.</p> <p>Regarding looking for 'objective evidence', I'm not sure how this would work for example in assessing a person's energy levels or levels of pain. If I'm experiencing a great deal of shoulder pain on a given day, then my ability to do everyday tasks such as cooking, dressing, getting in and out of the car etc is seriously impaired. However on a day when I don't have shoulder pain, I feel and am much more 'able'. I'm not sure what 'objective criteria' could be used to assess this though.</p> <p>I think perhaps the assessment process shouldn't be a simple 'one take wonder' or snapshot of a person's condition on only one specific day; it needs to have the flexibility to cover the full spectrum of a fluctuating condition.</p> <p>8) I think the assessment should take into account the aids and adaptations a disabled person uses. However, I also think that it is unfair to expect a disabled person to fully fund some of the more expensive aids or adaptations out of the personal independence payment. For example, the ability to ensure personal hygiene should not be dependent on whether someone can afford to have a bath hoist installed. There should be some statutory financial assistance with this sort of very expensive adaptation which is regarded as vital to basic hygiene and health.</p> <p>On a personal note, without my wheelchair (which I was lucky enough to be able to pay for myself), I would not be able to move from my bed. It is therefore essential for any independent existence. I could take a wheelchair provided by my local wheelchair service, but the model provided would be too heavy for me to get in and out of the car unassisted and so I would therefore be very restricted in my independent mobility. I am able to work and pay tax because I can get in and out of my car and go to the office.</p> <p>I think what needs to be considered is how far the state should fund 'independent living'. An NHS wheelchair would enable me to get out of bed and to push myself out of the house for a few hundred yards, or further by taxi. However, it would not enable me to do my job - which involves travelling to an office - other than by paying for taxis which would be prohibitively expensive. By funding my much more lightweight (and expensive) wheelchair, the state would be enabling my much greater independence and quality of life through participating in work and other activities. And - incidentally - recouping some of the outlay through my taxes.</p> <p>The question then becomes, how does the state define 'independent living' for the purposes of funding the personal independence payment?</p> <p>10) How about asking the applicant to fill in a journal or diary for 7 days, detailing their activities during that period, the time and effort (and cost - financially, emotionally, physically and mentally) each activity took, and what help they required to do each activity (whether from aids &amp; appliances or other people) and asking them to rate on a numbered scale (e.g 1 to 7) how easy or difficult each activity was.</p> <p>Medical professionals other than GPs should be contacted also e.g consultants, physiotherapists, occupational therapists, counsellors or other mental health support workers.</p> <p>I think GPs are too busy and time-poor to be fully aware of the psychological and emotional impact of long-term disability. This is why it's important to include evidence from other professionals who are more likely to have longer-term and ongoing therapeutic relationships with applicants.</p> <p>I also think it's vital to include personal statements (such as the diary idea) from applicants, which though they may not be 'objective', nevertheless provide an insight into what it's like to live with the disabling condition and to experience some of the barriers which can be 'objectively' identified. For example, the experience of chronic pain or fatigue is notoriously difficult to quantify in any objective way, and yet these can be amongst the most debilitating and restricting aspects of a disabled person's life.</p> <p>11) Benefits: the opportunity to present your case in person, with the chance to ask questions and clarify points</p> <p>Difficulties: embarrassment, difficulty that some people have in expressing themselves clearly, particularly in a situation where they might feel 'on trial' or seeking approval. The difficulty for some people in travelling to other locations might be very off-putting to some potential applicants.</p>
ONLINE309	<p>1) My son is autistic and is frightened to mix with non disabled people due to being beaten up and bullied at main stream school. He does not trust people.</p> <p>3) 1 . To get a child minder for a disabled child costs a lot more and it is very difficult to find anyone who is willing to mind a 14 year old boy who is 5' 9 " tall in a size 11 shoe !</p>

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	therefore i as his mother cannot get a job.
ONLINE310	<p>3) I work full time to support my family as my husband has MS which although he worked with for many years has gradually deteriorated to the stage he needs a lot of care. He was main wage earner and although I have had promotion our income as a family has drastically decreased. He cannot dress or wash unaided and spends long periods of time alone. He has carried p/t work and vol. work but can no longer drive and his memory and coordination are poor which has limited his options. The impact on my family is great although I received help to convert bathroom but his inability to balance means equipment like shower doors, shower and toilet seats are regularly broken but there is no support to replace these. The heating is on constantly and there is now a charge for emergency call out warden and attendance at Day Centre (when places are available). However if I refused to dress or wash him I could get this personal care for no charge but I want to help him hang onto this shred of dignity so don't have help. I don't have a lot of time free as I have 2 children and a house to run and sometimes feel if I left him it would cost the social services a fortune to provide the care I give freely. It seems you lose your main income and if this is not enough of a blow you then have to pay for all costs of having your house turned into a nursing home with no support for repairs, which believe me using a wheelchair in an ordinary sized family home are frequent and ongoing. It is easy to see why people just throw in the towel with work and claim benefits as it is tiring and emotionally draining to care for spouse and work full time and run a house and yet still feel that you have to justify your need for benefits when you just wish they were well enough to work and none of this had happened.</p>
ONLINE311	<p>1) Inability to access public transport and public venues (pubs, etc.). No wheelchair accessible toilets in those buildings when you do get into them with help. Public attitude is quite hostile since the government introduced its' "benefit cheats" campaign - most people seem to think that all disabled people are cheating the system and don't deserve the extra money they receive in the form of DLA. The fact that we have to pay people to do the most basic thing such as changing a light bulb doesn't seem to register with them that it's more expensive to live if you are disabled.</p> <p>3) Excessive energy bills due to the need for extra warmth (as not able to move around much) and having to dry all laundry in tumble drier  Need to have a large, automatic, vehicle to accommodate carers and equipment when going out - also need expensive adaptations to the vehicle  Carers needed when going out in order to access venues  Help needed with ALL household tasks - even changing a light bulb</p> <p>5) I believe that some conditions and impairments should mean automatic entitlement - those that cannot be improved, such as paraplegia, loss of limbs, learning disabilities, etc.</p> <p>6) Is this to be incorporated with care packages currently delivered by the Local Authority? At the moment a care assessment is carried out and the Care Component of DLA is taken into account by the Local Authority when charging for this help. Obviously if the care component is going to be set at a reasonable amount in order for the disabled person to be able to employ carers (and have a choice as to what support these carers will give them) without going to the Local Authority for their support then this would no longer be the case. If Local Authority support is still going to be needed then they are the ones who will still prioritise and provide support to those people least able to live full and active lives.</p> <p>Activities most essential are:  To be able to be safe at all times  To be able to prepare food and drink safely  To be able to maintain a healthy and safe environment in which to live  To be able to go out in the community to access activities and be safe  To be able to have a choice in what we consider to be the most essential activities for our everyday lives</p> <p>8) I don't think you should take account of any aids. The NHS provides limited wheelchairs which are not always the best option and the Mobility Allowance has to be used to top-up a voucher to purchase a more suitable one and then has to be used to maintain that wheelchair. I would equate having to use the wrong wheelchair to having to wear a pair of shoes every day for at least 3 years even if they hurt your feet constantly. It also causes all sorts of structural problems. If wheelchairs are taken into account when assessing mobility, users could be stuck permanently with inappropriate wheelchairs because that is</p>

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	<p>all the NHS dispense.</p> <p>The underlying person is what matters, not what aids and adaptations can be provided - even if these were available freely the "one size fits all" system means that the individual has lost their right to making an independent choice and may have to put up with something that is not really suitable if they will no longer have access to the mobility component to make their own choices of equipment.</p> <p>It also can take many months to be able to get necessary pieces of equipment (For example it took 9 months to get a replacement shower seat of the correct dimensions - the OT wanted to give us a "universal size" seat which "most disabled people use easily" but was not suitable due to my husband's point of balance.)</p> <p>9) If you are making the new benefit tailored to every individual's needs I don't believe you can make information clear, particularly with regard to who is likely to qualify for it. I believe it will make it even more confusing.</p> <p>Unless you make the claim form with multiple choice answers I don't believe you can make it easier to fill in and your questions will have to be very specific.</p> <p>With regard to doctors or OTs' advice - this will have to be very specific with regard to the many disabilities and debilitating illnesses which exist. Many OTs and doctors do not have enough knowledge to make an accurate assessment. With regard to people with learning disabilities, this would be an inappropriate method as most people with this condition will agree with an experts opinion and say "yes" that they can do things just to please. GPs also do not have enough knowledge of disabilities to make an adequate assessment. In this part of the world most people do not have a social worker as their cases are closed once an initial care assessment has been carried out in order to reduce the case load.</p> <p>10) The best person to provide a clear assessment of ability is the disabled person with support from their carer.</p>
ONLINE312	<p>1) that is an impossible to answer question! Each individual will have different barriers and problems and there is NO simple answer to that. People are individuals and no matter the illness/disability they don't fit in a box. saying that for many many people money, or lack of is a huge barrier. without money you can not get many of the aids and treatments that ppl with money can get.</p> <p>2) Motability... although as yet I have not been able to get a motability vehicle I do hope to in the future. Being able to get a scooter or car makes a HUGE difference to someone with mobility problems. I bought a mobility scooter with DLA and without DLA I wouldn't have been able to. BUT this is not a one off cost... scooters/wheelchairs/cars/bathlifts etc etc etc all have to be maintained and replaced eventually. for myself my husbands health means he has problems lifting the scooter in/out of the car, I am unable to. Which is why, now that the mileage allowance has increased on motability cars [my husbands job means near 20000 miles commuting] we hope to get a vehicle with a ramp or lift fitted.</p> <p>Also the preparing and cooking a meal care allowance. This doesn't pay for someone to cook for me but at least helps with extra costs involved in getting a few healthy meals I can sometimes manage to heat in the microwave when my husband is at work. Being ill and or disabled means you have been dealt a huge blow... all life plans gone and all there is is getting through the day. There is no dignity... you are not allowed pride... you are made to feel guilty for being disabled these days. No respect... nobody listens.. it just seems to be a case of trying to catch sick people out... trying to find a way to stop helping those who so desperatly need help. trust me... anyone who goes through the humiliating, degrading and frankly terrifying process of claiming DLA or IB, sorry ESA, does so because they have no choice.</p> <p>3) extra heating costs... prescription costs, even with a ppc that thank goodness you can now pay monthly for it is still expensive for people who survive week to week... just. other costs depend so much on the disability/illness. incontinence pads... ready prepared food... carelink, I'm on the falls register yet cannot afford the carelink service. getting out of the house for a while now and then is absolutely essential but cost of transport and carers and aids</p> <p>5) some health problems do mean the sufferer is never going to get better and putting them through the nightmare of forms and assesments is frankly just torturing them. IF these people are on the top rate then they shouldn't be tortured... if not and there is the real possibility they could be entitled to an increase? Well then maybe... though I cannot help but feel there must be a better way.</p> <p>6) contact with other people. I myself find speaking to people extremely difficult... impossible often. But I communicate on line. I have a friend who has the same health</p>

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	<p>problems as I have and talking... via email... to someone who understand exactly makes a huge difference. I shop online and have it delivered. This means i STILL can do that jjob I used to do and not have to get my husband to take on even more. I f I had to choose.. and may have to soon... between my little car which when I am able healthwise to drive I love too... even if just to take myself to the doctor... but my computer is my sanity, whats left of it. To me a laptop is the most essential thing for quality of life for a severly disabled/limited person</p> <p>7) accept that people don't fit in boxes for a start. LISTEN to the claiment... many people have illnesses that make communicating VERY difficult and just the stress of filling in the form when whatever answer you give doesn't accurately describe you is awful and very bad for what is already ill health. A FORM will never be suitable for all illnesses/disabilities. Thinking that it could ever be is... niave to say it polittly. The only way it could work is if there was a different form, done by experts in the illness/disability for each different illness etc so the form a claiment filled in was for their health problem. Never going to happen so the mistakes... distress... and appeals will continue. AND the healthcare professional MUST be EXTREMELY knowledgable about the illness/disability. I suffer with a syndrome and the list of problems is long and one of them is difficulty in communicating and very poor concentration which make it difficult to talk to anyone. If the healthcare professional understands all the asspects of the illness then it is much more likely to be a correct assesment. I had to go to appeal court for DLA because the assesor had no idea of my illness at all. thankfully the people on the appeal did. So much extreme stress and hardship, and increased permanent healthcosts and a lot of tax payer money would have been saved if the healthcare professional had been as knowledgable. Common sense</p> <p>8) there are many aids and adaptations available that would improve my quality of life a great deal... but there is no way I can afford these. ie a stairlift.. a downstairs toilet... a large mobility scooter that can go off road. I cannot afford these or get help to afford these so would they be classed as easily optained?</p> <p>I use a walking frame with a seat... with it I can walk a little and sit a little so not reliant on a scooter I cannot lift in/out of the car. But I use this to go to a garden centre for an hour and it takes days to get pain levels back to 'normal'. The fact I can use this aid once or twice a month to get out of the house for a little while should not then mean I am assesed as being able to do this all the time... consequences.. payback... cost...physical and emotional of doing something with the 'aid' should always be taken into account. It is so very wrong to say someone can walk so far with a stick/frame etc and thats it. The Complete Picture must be looked at.</p> <p>10) the claiments medical history especially when it is a long term and/or permanent illness etc that causes disability. in that is diagnosis and treatments and prognosis from GP specialists physios etc etc. The GP is surely the healthcare professional who knows the claiments health problems. and friends and family who see the claiment every day and witness the problems first hand.</p> <p>11) IF the HP isn't knowledgable about the illness/disability then they cannot give an accurate assesment and sick vulnable people are caused huge distress.</p> <p>12) completely depends on wether the sufferer is likely to get better or at least improve some. people who have an incurable illness have enough problems getting through the day. I myself have the nhs saying [for over 10 years] that I am never going to get better and so cannot have treatments that would at least reduce my pain for a while because it would only be temporary... I struggle to afford the nescessaties so private treatments are impossible... then I have the dwp repeatedly checking to see if I have been miraculously cured. Stressfull and depressing. Why torture and terrify people who will never get better? The medical history of claiments should always be part of the process... there is diagnosis and all the treatments and prognosis in black and white. How this is not part of the process already is beyond my understanding</p>
ONLINE313	<p>1) anice response like - how are you doing? we'd like to know how you are - same system as lone parents if they are unemployed - meet an advisor or pip will be docked?</p> <p>1) It all vaires on individuals - but muchof it is awareness and social disinclusion - i am deaf for example i find it hard doing things like going to the shops and shopping as people usually rage at me for ignoring them when shopping as tehy continue to push their trolleys in me - sow hen my husband is with me he guides me tells me, things like going to events whereby although it shouldbe the hosts responsibility to organise interpreters its not always possible so its nice to take a friend along and feel accompaigned and reassured that if i dont understand or i become at risk they can help me- this usally incurs extra cost - eg</p>

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	<p>paying for individuals expenses or sometimes you end up paying for interpreters your self eg social events likes parties. Sometimes it depends on the literacy of the individual too as BSL is second language. you can try to change peoples perspectives but its hard work and draining at times.. social services arent much help like they used to be and only concentrate on adaptations to assist not the social aspect so thats difficult too .. leading a normal working life can prove difficult too - which is why most disabled people tend to fit into a lower professional role - eg i work for dwp - i know i have capabilities of an EO but i choose to be an AO as its less stressful which means i get lower wage etc than if i wasnt disabled .. lately i avoid social situations - it means its less stress and less worry but it is nice to be able to have support and DLA does help me overcome that - i think also if you were to introduce PIP for those who have a disability alike mine they should get more benefit from it - as ive seen stigmatisation whereby individuals who are deaf wont work as they say - oh well i get my dla so i dont need to work .. we need to get away from that culture. working does indeed help me, i hated it when unemployed but thankfully i have supportive husband whose parents are deaf so he knew what to do to get me work-encourage, support and listen..which i think you will find is what most disabled people need..</p> <ol style="list-style-type: none"> <li>1) it all depends on individuals</li> <li>1) loads it happens on a everyday basis as mine is hidden disability - people just do not think or arent aware i wish we could educate our children more and also make people realise but sadly you cant change everyones perceptions.. mine is usually a communication barrier and care and safety issue as im deaf - but others are more physical .. what people have to realise is we have to work harder to get what we need in order to maintain a better life</li> <li>2) i should be paid 4 weekly , and definitely not means tested</li> <li>3) transport eg taxis, adaptations, equipment, carers fees, guide dog fees, delivery of items eg shopping, interpreters, advocacy, telephone bills _ for those who are deaf as typetalk is expensive to use! stationary, bedding, clothing and incontinence pads, vitamins creams prescriptions,</li> <li>4) it may cause difficulty in people saying well ur more disabled than me so go careful some people are border line and need medium help x</li> <li>5) that sounds good as an individual may be better at coping with difficulties than another - but if other people of same capabilities find out it can cause problems - so when they apply may be worth you putting this in writing and making sure atos explains this to the individual - otherwise it would predict a riot!</li> <li>6) sounds very much like a care plan - good way of putting it - as i felt in past if you were deaf difficult to put down in old dla forms what i found difficult - and what i need help with on a daily basis . Its tricky the prioritising part but obviously you would start at top for those with chronic conditions but i think in general social well being, care and eating , living conditions are the main factors in life</li> <li>7) regular reviews from social services who will advise</li> <li>8) non as not all aids restore normality eg hearing aids- you have to be careful here as if you do this you will end up with people who will say they dont use and want adaptations so they can claim benefit</li> <li>9) DVDs with subtitles - tv advertisements, one to one communication, social services awareness, go awareness - go out and tell the world!!</li> <li>9) just communication and loads of it!!</li> <li>9) tricky as you will never fully keep people happy - but if the forms were easier and completed by someone for them it may help</li> </ol> <p>most deaf people find forms hard so may be best to have a personal advisor or social worker to do this</p> <ol style="list-style-type: none"> <li>10) specialists - GPs dont always have the knowledge they know u as an individual if they see you regularly but dont see you every day to know what problems you have</li> <li>11) a need for interpreters, and each advisor needs full disability awareness training - not just training but also to meet people who have disabilities eg like voluntary experience with groups so they can see what empathy they need! and yes there are hundreds of situations whereby those with disability or health conditions need face to face meeting - hard to say what thou which i think is why social serv may be an ideal position to say if its needed or not</li> <li>12) audiograms from audilogsits!! for deaf people - as the test they do for deafness is not fool proof!</li> <li>12) tricky - but if a persons condition eg are deaf and will always be deaf then it wont</li> </ol>

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	<p>change - but if they are working and happy then every few years even if its a form will probably help..</p> <p>and totally agree abt diffeent type of reviews</p> <p>13) im abe cagey abt this as sometimes people willahve dsiabilities who may find oit difficult to say if they have a change so perhaps a review would pick this out</p> <p>14) iveheard al sorts from legal, adaptions, hearinga id peieces phone equipment like testlink, faxes, list goes on!</p> <p>16) they struggle or save up like i do :-( so havinag n extra addition al payment would be fab!</p> <p>17) great idea! educational physchologist reports are great too x</p> <p>?) communication for deaf people - may be best to get a link herte with agencys like rmid</p> <p>?) definitely - tehy should be included but things are improving all teh time as well as conditions change so we need to becareful how we say they are eligiable - waht may suit one person may suit another but they my prefer it ina different way - down to choice and preference again!</p> <p>?) access to work, prior educational reports, work reviews in work place? specialsits updates and occupational health</p> <p>?) theyw ould become poverty - and very vunerable</p> <p>?) very important but people have become lazy and think thatit means they donthave tow ork tahst why ithink they should have a interview if tehy arent working and get more of a top up if they are working even if its 10 pounds - it willmake people work im sure !!</p> <p>?) advice from our specialsits and consulatants</p> <p>?) yes they save up at moment or dont get it and dream haha</p> <p>?) yes</p> <p>just someone who has empathy and wills upoortthem</p> <p>?) any benefits, care plans</p> <p>?) pelase listen as deafness falls on deaf ears!</p> <p>?) care adaptions , delivery communication adovacy</p> <p>?) they wouldntbe able to survive and also tehywouldnt be able to provide the right equipment to help people like us have abetter quality of life</p> <p>?) communication support and CAB, social services and access to work report?</p> <p>?) sounds good but ..i do firmly believe if you are ona lower category - that you should get muchmore if youare working eg blind people /deaf etc but if you are genuinely of a severe or profound disability then it shouldnt matter.. sounds harsh i know but it'll encourage them to work - even if its 2 hours aweek and not affecting benefit ?? ist hard as the older generation of people arent as educated as well as our generation. anotehr thing that worries me is that sometime peoples costs towards a disability may end up being much more costly one month than another? so is there a way they could apply for additional loan or support for this eg new wheelchair or old equipment or extra support needed.. iknwoit shouldbe responsibilty of nhs and social services but i know people who refuse to ask for this as they say the quality isnt as good. but pplease dont take away a persons independance tehyshould be able to decide when tehy need something</p> <p>?) i think anything that may be affect ing the child eg emotional support, care and education</p> <p>?) yes but like me if you are sever deaf big difference to profound so it needs to be clarified properly x</p>
ONLINE314	<p>1) In my case feeling so ill and exhausted (CFS/ME and Fibromyalgia), for over 30 years (I am now 48), so that I hardly leave my home and have no social life at all. Yet because the illnesses are 'invisible', I have been disbelieved by family, friends - and some health professionals for years. For some people with these conditions it is simply not possible to 'lead full and active lives', no matter how much they may wish to. These illnesses are not just a 'set of symptoms' but systemic, debilitating conditions that (in my case), make it very difficult to have any quality of life. More research is needed for these types of illnesses, to actually help people get better. It is no good trying to force people back into work when they are simply incapable of doing it, threatening them with reduction of benefits and making them feel that they are simply 'a drain on society'. To me that is a retrograde step and a very dangerous one.</p> <p>3) In my case it's keeping warm. I stay in bed when it's cold (not just on or below freezing), as I am on Income Support as well and can't afford to have the heating on. I also have to</p>

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	<p>wash frequently and launder bedding and personal clothing frequently due to 'accidents'.</p> <p>5) I think they should be based on the needs and circumstances of the individual applying, but those needs must be fairly assessed by someone who knows the claimant or at least by someone who is truly impartial (and not just trying to reduce the numbers of successful claimants), who listens and writes what the claimant actually says fully and accurately, and not what their own personal opinion might be.</p> <p>6) Personal hygiene, feeding oneself and keeping one's home clean would seem to me to be essential for day to day life. I have consistently struggled to do these things for over 30 years but because my illnesses (neuro immune diseases), are 'invisible', I am disbelieved, verbally abused, dismissed and receive no help.</p> <p>10) The claimant's doctors, counsellors, social workers, support workers and long term medical history if applicable. People who actually know the claimant and the way their condition affects them.</p> <p>11) I have CFS/ME, Fibromyalgia, SVT and severe asthma. I currently receive DLA. My worries are that some 'independent' healthcare professionals are still not aware of the severe limitations and impact the first two conditions can have on a person's life, and some still refuse to believe they even exist. Some seem not to listen to the claimant's answers properly, choose to ignore them or just minimise the overall impact being suffered. It often seems to me that far from being 'independent', the main focus of the healthcare professional in this role is to simply reduce the amount of benefit claimants, regardless of the severity of the condition, in the hope that they don't have the energy to appeal - which is clearly inhumane and unfair. Appealing against such a decision is extremely stressful, and stress exacerbates these conditions so severely it is enough to put people off doing so, despite clearly meeting the criteria for the benefits. I believe that the medical professionals who regularly see the patient are best qualified to make these kind of judgements, not someone who has spent only a few minutes in the claimants company, makes them do ridiculous, antiquated physical 'tests' which prove nothing in cases of CFS/ME and Fibromyalgia - it is the after affects of activities that are significant and disabling, and the systemic, all encompassing nature of the illnesses that (in severe cases), make it very difficult to maintain any quality of life.</p>
ONLINE315	<p>1) Public transport is still not fully accessible in spite of the 'Equality Act'. Many old buses still remain in operation and are not disabled friendly with steep steps to board them.</p> <p>The height of steps on many trains and the distance from door to platform are a huge barrier for many.</p> <p>Many bus stations and railway stations are inaccessible with no lifts to different levels. Many buildings remain inaccessible to disabled people.</p> <p>Disability access often requires a long walk up a ramp and/or a long walk to the disabled entrance around the building.</p> <p>The Post office fails to provide an adequate disabled friendly service - long queues, little seating and no available seating when making a transaction.</p> <p>Many stores, including national companies fail to provide seating.</p> <p>A lack of awareness in the general public of disability, particularly unseen disabilities.</p> <p>2) I am very concerned about the effect of the planned face to face 'objective' assessments on variable conditions like Relapsing and Remitting Multiple Sclerosis.</p> <p>People with this condition have good and bad days and can look and appear perfectly healthy and almost symptom free on a 'good. day.</p> <p>The picture can be very different on 'bad' days, particularly with unseen symptoms like fatigue, common in MS.</p> <p>Even with teams of specialist (i.e. medically qualified) assessors in different conditions it would be impossible to gauge how a person with MS and many other conditions will be on the next day or week, or month or year.</p> <p>I am quite well-informed about my condition but am not aware of any way of measuring or assessing the effects of fatigue on individuals.</p> <p>Will people with relapsing and remitting conditions have to reapply every time they relapse? This is the fear many people have.</p> <p>In my experience anxiety, worry and stress can exacerbate symptoms which can lower immunity leaving the person open to infections, viruses etc., most relapses occur following an infection. This is my own experience and it is only through careful and consistent self-management that I remain as well as is possible.</p> <p>3) In many areas of the country public transport is lacking and expensive. In my local area</p>

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	<p>the hospital and out-patients for people with neurological conditions has no direct bus link from many areas of the city. In my case it means 2 bus journeys with a long walk between bus stops when changing buses, so it is often necessary to use taxis.</p> <p>Good self-management means taking advice of health professionals like physiotherapists about appropriate exercise. The advice is usually joining a gym, tai chi, yoga, pilates to name but a few. Gyms and classes cost money even when subsidised by charities etc. transport costs are involved.</p> <p>Good self-management also means keeping active socially and being able to get out and about to support groups, cinema, theatre, shopping trips and taking holidays. All these activities are more expensive if you have limited mobility and need carers to help you. All the things that are the right of able-bodied people, disabled people should not be excluded from leading as 'normal' a life as possible it is our right.</p> <p>4) Why should having two rates make it easier? It would probably make it easier to exclude people from the new benefit. It appears that whether you can or cannot do something on a particular day will affect your entitlement to the benefit. As previously stated this will discriminate against those who have variable physical and mental health conditions.</p>
ONLINE316	<p>1) lack of money lack of affordable support example LA direct payments £11/hr staff employed by LA £18/hr</p> <p>needing 1:1 support to access college now loss of ILF means that no support available outside of classroom to vulnerable person with complex needs. Choice of 2 candidates for job, one aged 18 challenging behaviour LD ASD continence issues must be supported 1:1 at all times to safeguard self and others what are the options for employability? only options offered so far is permanent move from family home...which the person who is a service user does not want</p>
ONLINE317	<p>1) People will not always be aware when their condition changes or improves as it can be a gradual process. A yearly review would be the most appropriate way method except in caes of terminal illnesses.</p> <p>2) May require assistance completing the form and advice on re-consideration and appeal process. Local Pension Service are invaluable for this, as they are currently involved in this activity</p>
ONLINE318	<p>1) Lack of support to participate in everyday activities, some people need extra support when they go outside the home. Some people find it very difficult to travel independently due to poor transport systems and lack of accessibility. Lack of finances to access opportunities such as leisure, leaving people socially isolated and very little activities.</p> <p>2) A more complicated system, more forms and assessments to be carried out. A lot of people would miss out on services. People would have to wait longer for much needed services.</p> <p>Please do not put up any more barriers for disabled people and their families.</p> <p>3) Transport costs, higher utility bills, adaptations to home and car. Specialist play equipment for children, Additional space needed in the home for people with challenging behaviours. Replacement of washing machines and dryers. Extra laundry costs due to incontinence, replacement of bedding and towels. Special clothing and footwear. Special diets. Specialist equipment. Respite costs.</p> <p>5) All claims should be based on the needs and circumstances of the person applying, some people will need to be fast tracked and should have an automatic entitlement to the benefit.</p> <p>6) Essential activities include getting in and out of bed, getting dressed, having help with personal care including bathing. Help with meals including: buying the food, preparation and cooking. Help to attend social, leisure and employment activities. Help with communication, reading and responding to letters. Help with medication. Help to keep the home clean and the garden tidy.</p> <p>7) People with variable and fluctuating conditions should be assessed by someone who knows them well and can comment on their individual case eg nurse, GP or key worker.</p> <p>8) I do not think the aids and adaptations should be taken into account it is the person's underlying disability that is important. If this new benefit is taking a person centred approach, then people should have the choice to decide which aids and adaptations they want to use and when.</p>

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	<p>9) The form should be more accessible, introduce some simple signs and symbols. Leave more space for people to put down the comments. Keep the questions simple, ask people to describe a day in their life to give a fuller picture to the decision maker. Get disabled people and their families to help design the new form. Run some advertising campaigns to promote the new benefit and make sure that information is made available on the internet and sent out to local voluntary and community groups. Ensure that staff in statutory authorities know about the benefit and inform the people they come into contact with. Work with GP's to promote the benefit.</p> <p>10) People who are involved in the care and support of the disabled person are the best people to provide any additional supporting evidence, e.g. carer, key worker, health professional</p> <p>11) The face to face meeting would need to be carried out by someone who is very experienced in the field of the particular disability. I think it would be better to get information from a variety of professionals, social workers are already paid to undertake assessments, if there has been a recent assessment could that be used for additional information. GP's should know their patients and could be asked for additional information. I do not think that all people would need a face to face interview. Having experienced a medical assessment under the employment and support allowance procedures, I do not feel that the medical assessments would meet the needs of people applying for this benefit. Some people do not like meeting new people and the whole process could be very traumatic for them. If there are already professionals involved in people's lives who have undertaken assessments then why can't this information be used. If healthcare professionals are introduced then there would need to be a wide range of people to call on for the assessments, they need to have the skills and expertise to deal with some very vulnerable people.</p> <p>12) I think reviews are needed as people's needs do change over time. Wherever possible the reviews should be linked to reviews that the disabled person already has eg CPA meeting, community care assessment review. This would ensure that the reviews are dealt with by people who has the necessary experience and in some cases by a multi-disciplinary team. This review could be completed by filling out a form and sending back to the DWP by case worker, social worker, community nurse. When there are no other formal review systems in place then the person who carries out the review needs to be experienced.</p> <p>13) By making it clear that the benefit could be stopped if people have not let the Department know that changes have occurred. If there is a built in review system then changes will be picked up quicker.</p> <p>14) It would be good to provide people with clear accessible information about other possible areas of support. A list of national organisations with helpline numbers may be useful, e.g. MIND, Mencap Learning Disability Helpline, Autistic Society, MS, Scope etc. You should signpost and give guidance about a range of options, but this should not be linked to the eligibility for the benefit. People need to choose what support they want and when.</p> <p>15) You should not force information on to people, people can only do what is right for them at a particular stage. A parent with a disabled child may need lots of information but this could be overwhelming and have a negative effect on the carer's health and ability to continue to care. It is often carer's who will be using the information not the disabled person.</p> <p>16) It is not just a one-off cost, what about replacement, running and maintenance costs. It would get quite complicated as some aids and adaptations are funded under health. I think aids and adaptations should be kept separate and people should be able to spend the benefit as they wanted, without expectations or pressures.</p> <p>17) The eligibility criteria for children should be in line with adults to avoid discrimination under the Equalities Act 2010. Eligibility requirements may differ depending on age. It would be sensible to use the assessments undertaken by other professionals, eg asking for a copy of the statement or statutory assessment from Health and social care. It would be really important to ensure that children are assessed by people who know them and not subject them to the medical type assessment proposed.</p> <p>?) Ensure that good quality information about what other support the benefit entitles people to is essential. The mobility scheme is highly regarded by families. The extra disability premium are needed within the Universal Credit system to help meet</p>

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	<p>the extra costs that a family face if they have a disabled family member within the unit. For a lot of families DLA helps towards the costs of the disability but does not meet all the costs.</p> <p>?) People who currently live in residential care and claim mobility component of DLA will have this removed. This will cause unnecessary hardship for these people and place additional costs on family carers to fund travel costs for visits home etc. Many people without the mobility component will no longer be able to go out and access other activities as they are not covered within the residential setting, so there will be no choice or independence for them. This group of vulnerable people need to be protected from this cut it will have an enormous impact on them.</p> <p>?) Community care assessments could provide information and save time on face to face assessments, and be used for reviews.</p>
ONLINE319	<p>1) Attitudes need to be changed, especially by employers. Some disabled people can still work with a different work pattern. Transport, especially the London underground, prevent people from travelling into London. Some theatres are not disabled friendly and prevent disabled people from enjoying the theatre. Disabled people may need someone to help with their care so that they can go out i.e. swimming or to work. However, if they do not have enough money, they cannot employ and pay someone to help them. Also there are legal problems because of employment law and tax and national insurance may be problematical for the disabled person.</p> <p>2) No.</p> <p>3) Paying for taxis if they cannot access public transport. Paying people to help them get washed, dressed/undressed, with shopping, accompanying them to work/socially, help with cooking, housework, laundry including ironing. Paying for a carer to go on holiday with them which may be financially difficult. More help with heating costs. More aids may be needed but if the person has insufficient money, they may be disadvantaged i.e. purchasing a mobility scooter or wheelchair.</p> <p>4) As it is not known what each component will comprise, I am unable to say whether or not this new system will be easier. The person has to be assessed over a 24 hour period, from an holistic point of view.</p> <p>5) Yes some conditions should mean automatic entitlement. People who are born with mental health/learning disability/without legs/ legs that have been amputated. People born with a condition where it is known that it will continue to deteriorate should be awarded at the lowest care component until it can be shown otherwise.</p> <p>6) Being able to get washed and dressed, able to shower/bathe and wash, dry and style hair. Able to get up and down stairs. Able to get in and out of bed, getting on and off the toilet. Able to wash and iron clothes. Able to shop, cook and eat and drink. Able to go to work and/or take part in social activities i.e. swimming or a hobby. Able to access GP and/or other professionals in their treatment. Have someone to help with treatment that may be necessary at home. Able to assist with sorting out and/or take medication. Able to assist with mobility so that person does not become socially excluded and can go shopping or go to the cinema/theatre or go on vacation either in the UK or abroad.</p>
ONLINE320	<p>1) For my son it is others attitudes in general towards him. It is also noise etc but his disability is such that he will never be independent and the government need to recognise that for a lot of disabled people independence is not an option. Day services are a way for them to have a full and active life as are voluntary and community groups and in Nottinghamshire these are being exterminated by notts county council.</p> <p>3) Paying for others to support them in their care and in their social life. Transport to get around safely, clothing which seems to wear out or get damaged faster than normal, aids and adaptations to the home etc. and to get around, to eat and drink, to engage in interests or hobbies, the list is extensive.</p> <p>4) I feel that some people definitely have more needs than the lower rate and less than what for instance my son has. I visit for PDCS and complete these forms and feel that there is a clear difference between the present three rates that we have. By making two rates a lot of people will not get the high rate but are much worse than the lower rate. Some are definitely only entitled to the low rate and in some cases two can have the same physical diagnosis but react totally different and therefore have different needs.</p> <p>5) DS1500 cases should be unchanged.</p> <p>6) Support from others and in mental health or autism etc cases this is essential. Medical opinion should be quicker to access for the decision maker and if there is professional</p>

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	<p>opinion or support for the claim it should make it a priority.</p> <p>8) This will depend , as the cuts take hold and some councils cut their adaptations help it should not go against the individual as some have no means to buy their own adaptations and this affects their ability to access a life.</p> <p>11) this could be beneficial if the doctor is knowledgeable enough to make an unbiased opinion. In the case of my son it would be a waste of time, he is autistic with severe learning difficulties and there is a plethora of medical evidence and evidence from his day service/school etc that could easily back up his claim, this would be cheaper for me to send in than pay a doctor who might not be an expert in his condition anyway....although in this particular case it would still stand.</p> <p>13) there should be a form similar to the PC2 that asks specifically if there are changes and reminds them of the consequences of not reporting a change, this should be sent at least every two years.</p>
ONLINE321	<p>1) The problems preventing disabled people in leading fulfilling lives are many. They are too greatly varied to put into a simple list. Disability discrimination is still rife despite the protection of the DDA. Experiences of mine include knowing wholeheartedly that I have been denied interviews for jobs (for employers without the two tick scheme), purely based on my medical history as a person with MS. Under the Tax Credit scheme, I am worth less as someone with a disability than my husband who was on the same salary but with the 50 plus element. Why the difference when we earn the same? He was worth more than £50 per week, yet I am only £17.95 per week - where is the logic? Other barriers include the cost of long term my medication - my current prescriptions are £48 per month yet I have MS for which there is currently no cure. This in itself is a barrier. If I don't work my prescriptions are free, yet if I do work (on a salary of less than £20k a year) I have to pay out - why? I am contributing to society more than others in that I work a 35 hour week and pay tax. My life seems worth more to society if I claim incapacity benefit. This in itself is a huge barrier. Self esteem or poverty? That is my choice. At the moment I have poverty but some self esteem!</p> <p>I am sick of being sidelined and put down because I cannot walk very far , I am sick of being treated as "equal" when it comes to tax and other financial areas. My career cannot progress quite clearly because I am limited by the jobs I am "eligible" for partly because of the two tick scheme. I get sick - it is part of my incurable condition, yet I work through it. For what exactly? Declare or not to declare my illness? It is a tough choice and one that faces many. One of the real issues I feel disabled people face is that we are all somehow still deemed incompetent or mentally incapacitated purely based on outdated views of disability. This is one area that affects a huge number of disabled people. As I do not claim anything other than DLA, I am constantly unable to access career training external to my employer (a local authority) because I cannot afford it.</p> <p>2) DLA should absolutely stay the same as to change the system now would leave those newly diagnosed and struggling to come to terms with their disability, sidelined, demotivated and feeling worthless and "on the scrap heap" of life.</p> <p>To reassess those currently on DLA would add undue pressure to people who are struggling to be generally accepted into society.</p> <p>The DLA mobility element has given freedom to many many people, not least myself. I have chosen to use my DLA mobility component to pay for a motability car. Without this it would cost me a fortune financially. It would also mean from a health point of view that I would have to travel by public transport and therefore be more stressed and suffer discomfort that would ultimately end in me being unable to work due to ill health. If I were to lose my DLA I would then be liable for a financial commitment on the motability car - something I can ill afford. It would leave thousands of disabled people liable to the contract payments on their motability vehicles.</p> <p>The reassessments are being carried out by so-called independent physicians who have no idea of an individual's history. MS is a prime example - some days are better than others. This is grossly unfair.</p> <p>3) Extra costs faced by disabled people again are varied. Increased heating costs, increased water costs are just two examples. As someone with MS I have to have controllable central heating and therefore are limited as to where I could be housed i.e storage heating has little benefit whereas gas central heating is easily controlled and yet more expensive both to run and maintain in the long term.</p> <p>Constant increases in prescription charges are my main bug bear. At £7.40 per item I am now into nearly £50 per month medication costs for an incurable disease. The costs of my</p>

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	<p>medication has some months, due to financial hardship left me unable to afford the very medication that allows me to work and indeed to live a fairly full life. As health problems progress, costs increase. Costs of care are ever increasing. Costs of disability equipment are ever increasing yet the financial help available is decreasing at a rate that is hard to comprehend. Many people face additional costs for carers to come in and help with tasks that able-bodied people cannot even begin to understand. Rising fuel costs make running a car ever more expensive and to some unmanageable.</p> <p>4) Two rates per component would make things easier if it were managed consistently across the board. For example some people with worse MS symptoms than myself have been denied DLA whilst other people i have met with lesser conditions receive higher rates than myself. Consistency is the key. This area troubles me greatly.</p> <p>5) Those with long term, incurable, debilitating conditions (such as MS) should automatically be covered. If conditions such as diabetes and thyroid conditions are covered the lack of help for people such as myself is astounding in this day and age. I did not ask to have MS, therefore I cannot ever be able to say I can be "cured" if after more than 60 years treatment is still randomly available. Individual needs and circumstances should of course be taken into account, but there needs to be a formal consultation of the medical conditions currently covered for "free" or reduced-cost help.</p>
ONLINE322	<p>7) for those with varying conditions it may give the wrong impression during an interview if they are having a "good" day. Also it means over a period more help may be needed meaning increased need in contact to the DWP leading to increased workload for officers.</p>
ONLINE323	<p>1) Well, I would've thought that being disabled is a problem/barrier that prevents disabled people participating in society and leading independent, full and active lives. The answer is in the question!</p> <p>2) Yes, everything other than the application process. It is grossly time consuming and stressful for the applicant.</p> <p>3) Adapted vehicles, taxi fares, carer costs, wheelchair hire, being unable to earn a living.</p> <p>4) Why change it? There are already two components, that is enough. It is a redundant use of time. If the government wishes to make DLA administration more effective, it should, as I previously stated, focus on making the application process more efficient. This is the only real disadvantage to DLA. Otherwise, other than increasing the allowance overall, to reflect the rising cost of living (This is something that has not been discussed) DLA should remain largely as it is.</p>
ONLINE324	<p>1) Many people do not understand disability they just see people in a wheel chair. While problems of access are the most important there is also the problem of being understood if you have speech problems and needing a lot of face to face interaction. My husband cannot read yet despite telling the bank this he still receives letters, he cannot remember things like passwords or pin numbers. With out his car he would not be able to visit people in person to sort out his problems. His award of the higher rate mobility has been so valuable to him. Although we had to wait 15 years for it to become permanent the lack of worry about if it would still be awarded is wonderful. My husband had a stroke 18 years ago aged 40 leaving him unable to speak properly, loss off medium and short term memory as well as problems walking. In our view DLA was the best thing the previous conservative government could do for the disabled.</p> <p>2) The motabilty scheme. This has been particularly good for my husband he would be stuck in the house all week if he didn't have a car as I need a car for work and we couldn't afford two on my salary</p> <p>3) Paying for care when the main carer is not available or needs to take a holiday. Transport costs if you can only walk short distances or not at all. adaptions to the home to be as independant as possible such as extra stair rails, handles, lowering of switches, permanent ramps to steps, seats in showers. The whole revamp of the shower room to make the shower tray lower.</p> <p>4) Simplification sometimes means a loss of flexibility. I do not think that the current system is difficult to understand. There are many levels of disability and I think that you need at least three levels. Some people will not be bad enough for the higher level of help while the lower level might not fulfill their needs so a middle level will give more flexibility</p> <p>5) Some health conditions should have automatic entitlement but also be based on the needs and circumstance of the individual applying. You give an example of a stoke sufferer in my experience it can take a lot longer than a year to find out that the person who has suffered the stroke has longer term problems</p>

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	<p>12) It is difficult to set the criteria as every person is different. Some people have progressive problems which get worse with age. The greater frequency of review is more costly especially where a persons' situation has not changed. If a person has got to a point where it is obvious that their situation will not improve I do not think that there should be any review for some time say 5 or 10 years. My husband was told very early on that he would never be capable of working again but even so he has had quite a few reviews which worry and distrss him every time they happen. Disabled people need to be assured that the help which they receive will not disappear or change with every change of government the DLA has been really good in that respect.</p> <p>I find it difficult to envisage what different types of review there could be. We once had someone come to our home who was there for over three hours which was very intrusive. While completing the form did not give the right information and my husband lost his DLA only to have it reinstated permanently by a tribunal.</p>
ONLINE325	<p>3) My "Chronic" (D'rs description) epilepsy requires my wife to work part-time only in her job. Why? Because I need people around me to help me after seizures. This allows me to work and take a lot less sick-leave than I would if I was left alone to recover after my regular night time attacks. When circumstances left me alone without any care the other year I ended up "black and blue" after a series of seizures. This resulted in several days of absence from my government job. DLA has allowed my family to "juggle" my care, with the allowance being used to under pin our already modest incomes. If this sum is lost than I will simply become more beholden on those out-side my family for care, my work attendance will deteriorate and I will revert to being an "epileptic" with few prospects and a deteriorating level of self-respect and an increasing resentment at my lot. Please think before you act.</p>
ONLINE326	<p>1) Lack of support to live independently. Physical attitudinal, structural and economic barriers</p> <p>3) Heating bills, laundry costs, lack of accessible transport, add on costs of employing staff not included in care package, having to pay for two people if you employ a Personal Assistant or carer whenever you go out or on holiday. Breakages of appliances in your home. Meals out or in.</p> <p>4) No it will not make it easier it will just complicate matters. Getting Doctors to assess people who know nothing about that person will leave people without funding. The stress of reassessing people has already cause some people to commit suicide. Fluctuating conditions such as MS or ME will be impossible to assess.</p> <p>5) Yes certainly</p> <p>6) It depends in the first place what you define as a full and active life. For example most people looking at me would think my life is not full however through the support I have it enables me to become a full citizen.</p> <p>7) By listening to the person you are assessing they are the professionals in their disability/condition.</p> <p>8) No aids should not be counted. You may be able to get an aid to put a sock on but this would probabaly take a very long time. There are much better things in life to do than spend 30 minutes putting your sock on.</p> <p>9) By using accessible formats and shorter forms and providing independent advocacy for those who need it.</p> <p>10) The disabled person being assessed and their GP</p> <p>11) WE consider in my organisation that disabled people are the best professionals about their disability. I do not think it appropriate to meet in their home and if they have to meet a "professional" then how will they get to the meeting?</p> <p>12) One assessment only for those people with long term conditions. If people with fluctuating conditions have to be reviewed it needs to be done understanding that at the time of the review they may be better or worse then this should be taken into account before deciding to stop or increase benefits.</p> <p>13) By not putting the fear of God in them that they might have their benefit stopped.</p> <p>? ) Advise them that you can provide them the info in their chosen format i.e. Braille, tape, large print etc</p> <p>Yes provide with benefit claiming process</p> <p>? ) Institutionalism and worse poverty</p> <p>? ) Make it simple - make it public!</p>

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	<p>?) Religious, cultural, sexual orientation and sexuality. What affect the benefit have on the persons rights as a full and equal citizen</p> <p>?) Self funding, working, going cap in hand to Charities.</p> <p>es they should be able to pay for these out of PIP but where a personal contributes to their care package (never the intention of DLA) has a motability car and needs a specialist wheelchair costing over £10,000 there is simply not enough money. Repairs also have to be paid for at absortibtent costs.</p> <p>?) The financial strain placed on parents and other siblings.</p> <p>?) There is already too much sharing of information about disabled people</p> <p>?) Very important without DLA many disabled people would be confined to their homes and be in even worse poverty.</p> <p>?) What an absolute waste of public money</p>
ONLINE327	<p>1) 80% Financial as if you've got no money, you have "no choice".</p> <p>2) Have not received any so far (after 6 years) so any loss would not be noticed at present!</p> <p>3) At least double of those a "normal" person, some small examples: My husband's mental condition throws logic and good sense out of the window, so he breaks things, turns up heating too high, leaves hot taps running, constantly turns on washing machines and dishwashers, if shopping spends every penny he has or buys the most expensive items without thinking, leaves the phone off the hook, runs up calls on his mobile because he forgets to lock it, ruins clothes, shoes, household items, the list is endless....</p> <p>4) In our case, because my husband can "walk" we only get the lower rate mobility component, which doesn't fund a car, and this does not take into account that he cannot use public transport without very close supervision, or only if he is in the right "mood" to be crammed into a small metal box with a load of strangers! I therefore do not think it is easier to understand splitting the benefit into care and mobility, it would be better as an all round benefit, with a premium paid for mental disability perhaps?</p> <p>5) As before, I think any dementing or brain impairment condition should be treated separately and with an automatic entitlement to benefit, particularly as the "claimant" is in no position to claim for themselves or argue the outcome!</p> <p>6) To be "safe". To be "secure" in their home and not under constant financial threat. To be "mobile". To have the right and financial ability to choose what they want to do, where they want to go, and the the right that their families are not plunged into poverty and isolation through lack of money.</p> <p>7) Do not try and have a "universal" benefit. Split it between physical and mental, with the higher rates for mental disability and dementias.</p> <p>8) Again, this should be split away from the benefit surely. In our case, aids and adaptions do not really apply, but I would class my husband as severely disabled. Why do we need to be assessed for these?</p> <p>17) Our eldeset son (now deceased) was Autistic, and we went through hell and high water to obtain DLA for him becuae he had no "physical" disability. I return again to the proposal of splitting the benefit into physical and mental disability. If there is a combination of the two, the most debilitating disability should determine the award.</p> <p>?) Here is the rub! There should be only ONE assessment with ONE person for everything, including any carer's benefits, help with housing costs, direct payments etc. Our lives have been dogged with assessments, opinions, beureaucratic mistakes, and constant and unremitting demands to "fill in forms", to achieve nothing more than a poverty level existence. When one looks at the cost of administering and policing these benefits now, and from what you are saying, in the future too, a few wrongly awarded claims is a small price to pay to achieve savings in administration.</p> <p>?) This site doesn't work! Convenient or what!!! Try again!! Once a person has been diagnosed with a degenerative/profressive/dementing condition, how on earth is it fair or reasonable to "reassess" them? My husband has early onset alzheimers and DLA was awarded "for life", now we are living under the threat of another set of doctors saying he is fit for work under a new set of rules? Stressful or what?</p> <p>?) There seems little or no mention AGAIN about Carers and their families in the legislation, despite the fact that in most cases, it is Carers who suffer MORE than the disabled person!</p> <p>?) We have received NO additional "passport" services or entitlements, so any improvement in this aspect would be hugely welcomed.</p>

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ONLINE328	<p>1) My son is a paranoid Schizophrenic and due to changing his medication for health reasons was thrown back into the mayhem of schizophrenia. He will never be able to have a place of work due to his history, his incapacity to retain information, his mobility and other physical/psychological problems. Yet, I do not see the questionnaire accounting for these problems. Do you intend to commit my son to a life of incarceration in a hospital. With the help of DLA he is able to live a quiet, law abiding life, that allows him the capacity to travel, takes into account his voracious appetite caused by the medication, his periods of poor mobility, clothes that continuously have to be bought because his weight is out of control due to the medication. He also needs his support team (CPN, Psychiatrist etc)He will never be given work due to: A) Being in the State Hospital, B) He is mentally ill, C) He was trained in precision engineering but not longer capable. Just explain to me, please, what hope does he have? I would like to close stating that my son is a decorated soldier, decorated by the UN and the Italian Ministry of Defence as he saw action in [REDACTED]</p> <p>3) I personally suffer from feecal incontinence. People who think incontinence pads resolves all are very mistaken. I have high costs for washing clothes and bedding. I also have to buy underwear on a frequent basis.</p> <p>I also suffer from severe Fibromyalgia and my walking is impaired thus I cannot walk a long distance, I rely on taxis to get me to my destination and then the help of a person to support me. I have only the help of my mentally disabled son who is a Godsend. When the Fibromyalgia is at its apex I must have heating irrelevant of the weather and the increases levied on us by the Fuel companies. I list my ailments and ask you how you would cope if you did not have the assistance of DLA:</p> <p>Ischemic Heart &amp; Brain Disease (Cognitive Impairment)  Severe Fibromyalgia  Diverticulitis  Chronic IBS  Multiple Duodenal Ulcers  Benign Tremors  Eosophegal Motility Problems  Two Operations on one Incisional Hernia  Nissen Fundoplaction surgery  and finally, Feecal Incontinence</p> <p>5) I have, to my disgust, witnessed a person attend a tribunal, with crutches and on leaving dumped said crutches. For people like myself and many who are the genuine needy, I believe that where valid documentation is presented, and the disabilities are genuine then there should be an automatic entitlement to benefit. It is the so-called state of depression and "bad Back" brigade who seem to come out winners. Where there is a serious Mental Health and/or Physical Health problem there should be an automatic entitlement to benefit. Many carers do not receive benefit and put in hours of unpaid work, many genuine disabled people live in a poor fashion because of the costs entailed. Hit the con-artists and help the genuine</p>
ONLINE329	<p>1) A failing house of commons system to deal with ex forces that prevent disabled forces personnel participating in society and leading independent, full and active lives due to medical incompetence and maladministration to deal with past injuries.</p> <p>2) So what we have here then is clear and wilful discrimination against War pensioners - this part does not deal with this issue especially those that served before Iraq and Afghanistan but still had the same hardships and a worse system of care?</p> <p>3) Heating, a lack of ability to maintain a house. Adaptions to a house</p> <p>4) This fails to deal with war pensioners so how can people who receive this comment?</p> <p>5) Once again how does the new system deal with war pensions?</p> <p>6) How do you propose to deal with daily medical help and assistance for spinal injuries undiagnosed whilst in the forces...answer you cannot!! You cannot even deal with pain management effectively which limit activities that are most essential for everyday life? Your own doctors have some personal prejudices here!!</p> <p>7) It needs to reflect that age alone will not cause problems but that a condition will alter for worse. It also needs to deal with side affects from medicines and of course misdiagnoses?</p> <p>8) Of course they should, any aid or adaptations should be included.</p> <p>9) Link the form up to the War pension system!!</p> <p>10) My experience of meeting with these so called healthcare professional is that they have there own personal prejudices and have constantly failed to deal with any case notes or proven injuries. Statement 29 gives me no confidence whatsoever.</p>

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	<p>These are the same people who misdiagnosed me for some years and you are telling some of us to meet with them!!!</p> <p>The majority of the visiting Doctors receiving pensions and topping them up by going round with a form - making an ill formed opinion and then falsely filing in a form of which the system is now ostracising people who served this worthless country.</p> <p>11) I would not trust any of them as they come from a biased and wilfully prejudiced background, I can see no benefits whatsoever especially when it comes from having been in the forces!! That's the statement I would make then un-politely tell them to get out of my house.</p> <p>12) Why should they be reviewed if it is prove that their is a problem or do we have an element of a political discrimination here - of course we do?</p> <p>13) Which ones are we talking about War pensioners or the others?</p> <p>14) Get the RBL and other ex services charities to have an input in the forms.</p> <p>15) see answer to 14 above</p> <p>16) I would ask the RBL how much they fund for the above especially if this discriminatory government wants to intiate a Personal Independence Payment to meet a one-off cost?</p>
ONLINE330	<p>5. I BELIEVE THAT IF A LIFE TIME MEDICAL CONDITION HAS BEEN DIAGNOSED IE MS THAT BECAUSE OF THE NATURE OF THE ILLNESS IT IS NOT CURABLE AND IS A CONDITION THAT DOES NOT GET BETTER IT GETS WORSE. SO IF IT GOT TO THE STAGE WHERE YOU WERE UNABLE TO WORK THEN BY REMOVING BENEFITS THAT COULD HELP SOMEONE IN THIS SITUATION THEN YOU WOULD BE CAUSING MORE DISTRESS TO THE CUSTOMER WHICH WOULD HAVE A KNOCK ON EFFECT TO THIS PARTICULAR ILLNESS. THEREFORE I FEEL THAT CERTAIN ILLNESSES THAT HAVE BEEN DIAGNOSED BY EXPERT CONSULTANTS AND DOCTORS SHOULD BE AUTOMATICALLY ENTITLED TO THE BENEFITS. AND NOT BE SUBJECTED TO MORE PRODDING AND POKING BY OTHER SO CALLED MEDICAL EXPERTS TO SEE IF THE GOVERMENT CAN STOP ESSENTIAL MONIES THAT THESE CUSTOMERS RELY ON TO HELP THEM MAINTAIN A CERTAIN LEVEL OF FINANCIAL HELP THROUGH WHICH THEY MAY BE ABLE TO MAINTAIN A CERTAIN DEGREE OF LIFE THROUGH OUT THERE ILLNESS WHICH CAUSES ENOUGH PROBLEMS TO THESE CUSTOMERS AS IT IS.</p>
ONLINE331	<p>1) Prejudice is the biggest barrier preventing disabled person from participating fully in economic life. Employers find difficulty to recognise disability. Most of them fail to allocate appropriate work. For most employers have prime aim is profit motive therefore it is widely perceived disabled people are not productive enough.</p>
ONLINE332	<p>1) Disabled people meet barriers everyday. Society views them as second class citizens and the Government's determination to portray them as srougers encourages this. They have difficulties actually getting out into society. Most need help to get ready and to get out into public places. Care allowance and mobility allowance are essential to help the disabled to participate in society at any level successfully.</p> <p>2) The way it is assessed does not need to be changed. Disabled people have enough problems and streeses without worrying about the impact the prosped changes are going to make on their stannaed of living.</p> <p>3) 1.adjusting thier homes to accomadate thier disabilities.  2clothing and heating bills.  3aid with domestic tasks  4aid with personalhgyiene tasks  5mobility costs-whether public or private transport-needing other people with them to care for them.  6food-as many people can not cook fron stratch and need to buy more expensive ready meals  7wear and tear costs as braekages and adaptations are necessary.  8entertainment-many disabled people are cut off from society and lonely costs as breakages and adaptations are necessary.</p> <p>4) I thought that the way that it is structed at the moment already allows needs to be assessed. I think that new components will confuse people who are still trying to understand the present .</p> <p>The two rate system will result in many peolpe not being accepted in either band and therefore they will recieve less/no help and theu=ir stannard of living will be affected for the worse.</p>

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	<p>6) Enabling people to participate as much as possible in society workwise and socially. Therefore it is essential that this people have the access they need to care and mobility allowances to ensure right.</p> <p>7) The present system of reassessment at regular intervals achieves this.</p> <p>8) This is not acceptable in a civilised society, If people need aids then therefore they are disabled in modern society. Aids are exactly what they say - they are aids. They do not make a person whole. Many people do use aids such as wheelchairs but still need help. Even people that can wheel their own chairs for a distance can't wheel themselves up ramps easily. They can never be as mobile as a person who is not disabled. How can people dependent on aids achieve everyday tasks in an easy fashion? Aids should be noted but people should not be penalised for their use. This assessment proposal implies that people if they can move at all will be penalised and not receive the vital support they are morally entitled to.</p> <p>9) 1) It is far too late to inform the public about change. The new proposals are happening very quickly and will be in place before they have had a reasonable amount of time to be aware and educated about them. Any claim form is complicated and adverts on tv and leaflets posted to homes may help but this would take time and be expensive. Thereby asking the question Is change necessary and will change cost more to implement than it saves?</p> <p>10) The letter written by the person themselves or a person that knows them as is already in place on the present claims sheet. Many doctors do not know how their patients struggle in day to day living. Consultants and other professionals are limited on what and how they can comment on patients needs and disabilities.</p> <p>11) As the people themselves and professionals submit written statements I think that it would be most unnecessary in the majority of people for this to be appropriate. Face to face meeting can be intimidating and stressful and people can feel violated. So in most cases meetings are not necessary.</p> <p>12) Reviews should be designed to ensure people continue to receive the help that they need, Needs may change for the better and then return to previous levels so I think that 2-3 yearly assessments are fair as fluctuations in needs have to be taken into consideration. A good basic review should be able to deal with individuals and their needs.</p> <p>13) It depends whether an individual is capable of assessing their change in needs. People with degenerative diseases and mental health issues and most disabled people have mobility problems and therefore can not easily be expected to report every little change. The fear of fines may and will deter a lot of people claiming the help that they need and are entitled to.</p> <p>14) Having to apply for one off payments for adaptation etc will only add extra stress and hardship to disabled people's lives. The system in place is easier to access. In the present economic climate when the NHS and local councils are cutting back disabled needs are unlikely to be a priority and therefore unlikely to be met.</p> <p>15) No- this is beginning to sound very intimidating for claimants and lots of people do not have access to computers and struggle to get out to information centres etc.</p> <p>16) They incur the costs themselves or rely on the NHS. One off payments would take time, be stressful and some claimants would need help and support to make a claim.</p> <p>17) Surely a child is entitled to support in the same way as an adult. Yes their needs will change as they develop but they should not be penalised for this. Any disability needs to be recognised and treated fairly. Some needs may be met by schools that child still relies on the family 24 hours a day, the family still needs financial support throughout their child's development.</p>
ONLINE333	<p>1) Cutting help for people with lesser barriers to leading independent lives could lead to greater expense for the state in the long run. Their condition could deteriorate because of lack of funds and they could end up needing more expensive support, such as hospital or care homes.</p> <p>2) Leave DLA as it is rather than spending money on changing the whole system. Spend the money on some decent publicity for the existing system to explain to people what is all about and providing independent people to help people fill in the forms. You also need to do more to educate the general public that this payment is to enable people with disabilities to live a full life not a benefit. I can't see how changing the name is going to make it any easier for people to realise they are eligible to receive it. In fact it's going to cause confusion and anxiety and calling it Personal Independence Payment makes it less obvious that it's linked to disability. The mobility element should still be available to people</p>

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	<p>in care homes who are funded by the public. My brother is in a care home. The fees (paid by the Local Authority with a contribution from him) do not cover transport. He pays some of DLA Mobility towards the cost of the home van. When he uses public transport he has to have one or two people with him because of his condition and he has to pay their fares as well as his own. So the DLA Mobility is vital for him to be involved in an 'ordinary' life as well as attend medical appointments etc. The local authority don't have the money to pay for the transport as well and probably base the negotiations over fees on the fact that residents will have DLA Mobility.</p> <p>I also can't see why you can't check continuing eligibility within the existing system. People in care homes publicly funded get a review each year. You could introduce a check into eligibility for DLA at that stage.</p> <p>3) My brother's main extra costs are having to pay people to support him to carry out most of daily activities, including personal care, interacting with other people, dealing with correspondence including bills, shopping and meals, transport, dealing with anger etc.</p> <p>4) I think you need 3 rates for each component to help a larger range of people and recognise the range of help people need.</p> <p>5) You should extend the range of automatic entitlement not get rid of them. People with disabilities have enough to cope with in their lives apart from having to jump through hoops to get the help they need to be able to do what most people in society can do. There is no way to simplify forms - it's been tried before and it's never worked. The only way to simplify things is to have the fill the forms in and go to assessments less often.</p> <p>8) I think that you should only take account of aids and adaptations if they don't cost anything for the person and only when they have been proved to work for them.</p> <p>9) Have an independent advocate available to help you fill it in. There are charities that offer this service now - it should be provided by the state. Having one form that covers all relevant benefits would make it easier so that you don't have to keep filling in the same information asked in different ways.</p> <p>It's easier to understand what benefits are about if someone explains in person - but start with publicity for everyone not just people who are eligible. TV and radio adverts, teach people in schools and colleges as part of the curriculum, community groups, churches etc.</p> <p>10) The person themselves and someone who supports or interacts with them on a regular basis are best placed to provide supporting evidence. They could keep a diary of what they actually do and what they can't do because they need help. Someone who sees them on a one-off assessment is NOT best placed to provide evidence. People often have good and bad days and basing the decision on one visit could be misleading.</p> <p>11) Some people have problems with communication apart from the obvious hearing loss and loss of speech, for example people with mental health problems and autistic spectrum disorders.</p> <p>These difficulties might be undiagnosed so people would need to see a range of professionals to pick up any problems with communication.</p> <p>12) People should have access to independent advocacy to help them with reviews and forms. People often have good and bad days and these should be taken into account if they happen to be seen on a good day.</p> <p>You should give more weight to the opinion of the person themselves and people who support/see them every day not just a professional who sees them once a year for an hour or two. And often in my experience only sees them once and never sees them again - often basing the review on inaccurate reports from past years which don't get changed even if challenged.</p> <p>13) In my experience, even if you report something like a change of address, which does not affect how much you are entitled to, payments are stopped without notice. You then have to make lots of phone calls and complaints to get them re-instated. This is a disgrace. So to encourage people to report changes you need to make sure that payments will not stop suddenly while you investigate and promise people this is the case.</p> <p>14) Free independent advocate to help with the application process including representation at meetings if required by the applicant</p> <p>They need to be able to try out aids and adaptations before deciding they will work for them.</p> <p>The payment should be a right not a benefit.</p> <p>?) DLA should be used as a passport to other services or entitlements. There should be links to local authority community care assessments, which don't seem to exist. You fill in a form for DLA which seems to overlap what is covered by the community care</p>

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	<p>assessment but social workers repeat the same process all over again. The same happens when you apply for benefits such as incapacity benefit. If you have a low income and get a benefit such as pension credit guaranteed you automatically get other benefits based on low income without having to fill in another form. The same system should happen if you have a disability. Once you have filled in one form describing your needs that should cover all the other payments and support based on those needs.</p> <p>?) They would be forever filling in massive forms, which would need to be processed costing the state more money in administration, as well as going to more assessments. It could put some people off applying for things they are entitled to and as a result their quality of life and those who support them would suffer. In the end it could cost the state more because their condition could deteriorate because of lack of funds and they end up needing more expensive support, such as hospital or care homes.</p>
ONLINE334	<p>3) I am aware that families have been known to utilise the mobility component to keep the family in a car, but for those living in rural areas a car is becoming more and more essential for people with mobility issues. Those living in residential settings have an even greater need. Diminishing budgets have meant that providers are no longer able to provide transport, therefore it is over to taxis and public transport, which are becoming increasingly expensive.</p> <p>The rise in the cost of daycare, and the closure of some facilities, have added to the need to have a vehicle as the people we support now have to travel further to services provided in Plymouth. Without a car there would be a great deal of waiting around at bus stations, which may cause difficulties for these vulnerable people, also extra expense if cares/support workers have to wait with them.</p> <p>4) The system would be much easier to understand if there were just two rates. Eligibility for the higher rates should provide an automatic passport for DFG's, care/support, mobility badge, etc.</p> <p>7) Ongoing assessments should be GP supported/advised. There should be a link between the Health sector and disability benefits to ensure that someone is continually eligible for the benefits they are claiming. If someone has not visited the GP for more than a specified length of time then the benefit should be reviewed.</p>
ONLINE335	<p>1) Lack of money, lack of confidence, lack of opportunity to work. More expert retraining and confidence skills needed.</p> <p>2) We should retain the organisational ability to help vulnerable people with DLA claims in their homes either through Local Pension Service or some other route.</p> <p>3) Complex travel arrangements, more expensive food items such as ready meals, now having to pay for home support as LAs reducing/withdrawing free provision.</p> <p>4) It should simplify and clarify both customer info and administration, but will clearly disadvantage those with less severe disabilities such as those who can't prepare a meal from scratch and would previously have got lower rate care component.</p> <p>5) Terminally ill, long term sight impairment, anything that medical opinion states is unlikely to change. We need a better way of assessing/verifying 'terminal illness'. I'm aware of people passported onto DLA who are still getting it 10 years later with no check on what that person can do for themselves. This has to change as it's unfair to other customers, and the taxpayer.</p> <p>6) Getting in and out of bed, to and from/on and off the loo, dressing/undressing, keeping safe, feeding yourself (and realising what you need when).</p> <p>7) Introduce an 'average' assessment, rather than 'at their worst'. With sufficient medical knowledge plus the customer's input it should be possible to gauge, say, the approx number of days per year on which an individual might need help/struggle with 'independence'. Currently people are getting through the gateway for conditions which seriously affect them only on relatively few occasions - perhaps five or six days per year?</p> <p>8) Of course it should. Everything from prosthetic limbs to guide dogs. Few people who work are 'completely healthy' (whatever that means). We all have to adapt to physical and mental challenges and most of us do that to the extent that we can do paid work and live fairly full and productive lives. A soldier who, sadly, loses a leg and learns to walk again with a prosthetic device is no different.</p> <p>9) Set out the conditions in clear bullet point terms on no more than half a page. Give examples of who might and might not qualify (this is critical I believe). Then just ask for ID and signature if people think they might qualify - and have the medical assessment do the rest.</p>

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	<p>10) Supporting evidence should be optional but not a central part of the assessment process. We know some Doctors will back their patients to the hilt, but they either don't know the conditions for the benefit, or do but are prepared to say anything to get their patient the extra money that they think will help. Let's train our health care professionals incredibly thoroughly and consistently on benefit conditions and leave it up to them. Let's also word our legislation to give their opinions due weight. Internationally recognised consultants speaking emotively about terrible illnesses is all very well but, again, they don't know the benefit conditions. Their points are just as often political and trying to 'bend the benefit' to fit their patient. Let's ensure our assessors are on an equal footing, because they do understand the system.</p> <p>11) I spent 12 months of my career answering complaints about Doctors. What that told me was that in any system involving medical professionals CONSISTENCY is of paramount importance. If this system is going to build credibility from the outset and retain it over time it will be critical that professionals are trained nationally to exactly the same exacting standards leaving, ideally, nothing that's open to personal interpretation. Every circumstance must be covered by training to leave the minimum to chance.</p> <p>12) Bearing in mind the amount of taxpayers money being spent and the way in which people can adapt and conditions change, I believe 12 monthly face to face assessment in the customers home should be the norm. That would show the adaptations already provided to help them, and how they function.</p> <p>13) By 12 monthly assessment in the customers home.</p> <p>15) I strongly believe that DWP should retain the ability to advise and help people about their claim both by phone and in person. And I do not beleive it's appropriate for us to refer customers to welfare rights organisations whose funding is based on the numbers of people they get onto the benefit. These people lie on behalf of their customers. I have first hand experience that tells me this. I've known very many expert and caring members of advice organisations who have immensely enriched their customers lives. I pay tribute to these people and hope I can count myself one of them after 5 years helping folk get AA and DLA. But these funding arrangments are a standing temptation for some, particularly those based in LAs. You have been warned!</p> <p>16) Motability cars should only be available to help disabled people actually drive with adaptations. Most vehciles are bought in the disdabled person's name, with their benefit, then used daily for purposes that have nothing to do with them. A checking regime would be too expensive. We need to greatly restrict the provision of such vehicles.</p> <p>17) For the under 5's just this: none. If parents are doing their job properly, the under 5's require constant attendance and supervision. I know mine did. I don't believe we can justify benefits in anything but the most extreme cases for kids of that age. After this, kids start to become more independent, and something could be considered for over 5's but what is it that we're trying to compensate for here? I'm forever helping my kids and running them here or there and they're healthy 18 and 21 year olds. Good friends have a Downs boy and I feel desperately sorry for them and very much recognise the extra worry. But in independence terms he's really just a few years behind other kids of his age emotionally: he's very physically independent, a really nice guy, and looks fully able of holding down a job when the time comes. Should we be paying benefit for people like this when 'normal' kids are so different from each other in terms of their development? I don't think so.</p> <p>?) I think most DWP staff (except maybe those wedded to an old style Decision Maker role) accept the need for reform of the gateway to make it fairer and more secure. We've all seen people getting DLA who shouldn't (usually in the press) and many of us have experienced first hand the sheer difficulty of helping someone fill in the form who you know should get the benefit but either doesn't want to admit what they can't do, or doesn't fully understand what they're being asked. Also Decision Making has always been inconsistent. Anything that can cut any of this down is a good thing, and assessment by 'health professionals' is perhaps as good a way of simplifying as any other, though it'll have a cost. I have a few concerns:</p> <p>Process and Training: let's design the process to make it as transparent and consistent as possible. And ideally we'd train all health professionals at the same course, with the same material, by the same person, to hammer home the 'consistency' message. Nothing will devalue the new system like inconsistent interpretation. You'll never remove it totally but we need to be seen to be minimising it as much as poss.</p> <p>Status: It'll be our 'Health Professional vs Expert Consultant' at appeals so let's make sure the system gives specially trained folk's opinion due weight. Does this mean it's a job for</p>

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	<p>'doctors' rather than 'nurses'? The BMA would probably think so. But I realise this causes other problems of cost etc and (ironically) of political BMA involvement!</p> <p>Motability: let's give this a really hard stare in the current economic climate as to whether it's affordable at all, and whether help is really effectively targetted rather than at 'family freebooters'. Or is it really designed to give our car industry an unrealistic boost?</p>
ONLINE336	<p>1) Largely based on the incorrect assumption society makes about established ways of doing things being universally assessible which fails to recognise there are alternative means of inclusion. Often people who are 'differently able' are able to participate equally by having the freedom to find alternative methods of assessing or achieving the same end outcome. However in order to overcome the barrier created by an assumption that 'everybody will do "it" this way' may require resources with additional cost and/or time implications that would not be incurred by everybody equally. Those additional cost may arise through differing transport needs, the extra costs attached to specialist equipment needed to access IT or communication equipment, or adaptation needed to physical environments. Potentially the need to have the assistance of another individual to acheive equality of access may also generate additional costs.</p>
ONLINE337	<p>1) the main restrictions I face on a daily basis is the lack of understanding people have of my disability. I have never expected anyone to know what its like growing up with my form of Cerebral Palsy, it is rare and as yet I not met anyone in the UK my age that I could even talk too. This leaves me feeling very isolated. my GP and specialist do not know just how to help and I tend to get left to deal with the effects of it myself. I have learnt in my 38 years to understand when I can't do stuff and would like to be able to express these to others, but just how do I do that? how could I expect anyone to understand just the level of pain and emotional frustration I go through on a daily basis? just why would I want too open up and make myself feel so worthless by everytime I have a bad day I have to explain just why I can't function. I am often getting told of work █████, you can't do that its too dangerous. yesterday you where very ill trying to walk and I don't want you doing that today. But! But! today I feel fine! No █████ you not doing that. on revese I get why is that too much to ask. you where able to read yesterday why are you finding it confusing today. its quite simple isn't it!?! I don't know is my reply. I have just recover from a seizer I don't know what I thinking, But can I tell work this? no would I want to go and see a specialist about this NO! its personal to me I don't want everyone to know just how my disability effects me it makes me feel even more worthless</p> <p>2) I feel that self assessment should remain the same. I know my disability better than anyone. I spent a considerable amount of time filling out forms to get my DLA and was awarded it for live. my disability isn't going to get any better and I don't feel that I need a change. I feel the benefit of having a mobility car helps me a great deal this I would like to keep. I feel for those who have been awarded DLA for live shouldn't have to go through the whole process again</p> <p>3) the main costs isee facing disabled people is the price of everyday stuff that normal people can do without. things like petrol. as a abled person if I wanted to walk to the local shops I could but as a disabled person I can't I need the car to get there my local council has now started to charge for disabled parking. the cost of petrol has gone up the reflection of this is not shown in my benefits. there are days I am unable to function cooking is difficult for me I will often drop stuff and my dinner can be wasted. I struggle to eat my dinner will go cold and I having to reheat it sometimes I don't know and it makes me ill because I have very little taste. I need someone to help me with this. I had to by my own AAC device as the government do not provide communication aids to disabled people. I use the internet to communicate but this is an additional cost on my mobile as well as home. I ould be writing all day about costs but I feel you get the picture</p> <p>4) I found that when competing my DLA having two components made it hard to understand. a lot of disabled people need help with mobility issues to get around due to their mental health but they are able to walk normally. this doesn't mean they are able to get on a bus like everyone else. take autism, this is a very disabling impairment but is very hard to claim under any benefit the government has or is propossing. the ability to walk is not always provided on ones ability to use their legs. getting out the house is hard for me. I have a hearing loss and the nosie of the street is confusing and upsetting at times if someone shouts at me because I am in the way. I may not hear an announcement at the station if I want to get into London. I use Hi Tech devices to help me with this but this is an additional cost. my ability to get into London or even into work doesn't rely on my ability to</p>

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	<p>walk even if that is a great impairment for me but my biggest problem is understand where to go and how to get there. asking for help not hearing replies. I much rather take a car but this isn't because an train is impossible for me but just I can't understand. this isn't reflected in having to components</p> <p>5) it seems to me that some disabilities do need to have automatic claims. it makes sense to award additional support if needed due to multible impairments of that person. but having a base line award for those needs means that the person knows if they have that condition they will get an automatic award. this then saves everyone time and effort. under the current system the time it takes for application and getting awarded DLA is far too long. it took me 3 years to claim mine and caused me great stress. at one point I was really to give up and kill myself. I don't see just how by increasing this time for you to look at every claim is going to help matters specially when you say this is to save money and laying off staff</p> <p>6) I had to read this twice before responding. there are a number of issues that do not come in line with what you are saying. you talk about activities for every day living. having worked in social care for 22 years I grew up in a residential home and worked in 2 since leaving school. however the government are stopping funding for many residential centres and disabled people are having to fund their own care within their own homes. this has means they are being left isolated and without people to support them on a daily basis. when residential care is provided you stop payment for these people leaving them locked up in residential care and feeling isolated for from the community. I don't see how you can have it both ways? on a personal note I enjoyed my time in residential care. I was with people who understood my disability. I didn't have to explain everytime something went wrong and I didn't have to employ my own staff. when I turn 18 this all stopped. This is why I went to work in a residential home before funding for those also stopped. you talk about activities for disabled people but then take away the very means for that person to carry out an activity. I do understand you are talking about more practical tasks/activity like cooking, washing and looking after one self but these activities are totally pointless if the disabled person doesn't have the means to be included into the community</p> <p>7) this is always a diffcuilt one to reply too. my condition changes a lot and in the winter I am much worse than in the summer. you have talked about different compoments in pervous questions but as in DLA you have broken these into two components. as stated in my response you are repacing a broken system with one which seems from my view even more broken. later you asked about activities. it would make more sense to me to break any assessment up into a live in a day of a disabled person. record a week of that disabled person what challenges they have face or are likely to face to lead a normal live. working with people with learning difficulties and having talked to many disabled people about this reform the question that comes up again and again is just how am I going to be assessed? unless people spend a whole week with me just how are they going to know what challenges i face? as I have said I am much worse in the winter this I know is true of many disabilities I need extra support in the winter and cost of heating goes up. it would seem fair to me if an diary is more useful asking key questions within a day of a disabled person. things like are you able to get out of bed unaidded? who looks after you at night. those sort of questions.</p> <p>8) as stated in a pervious response. I use many aids to help me function on a daily basis. some of these where brough for me by access to work but this ment I had to get a full time job in order to benefit from this adaptations. I see the benefit of working but there are many disabled people who are unable to work. I don't feel it right that I or other disabled people should be forced into working just to get speicalist equiepmnt that will help them in everyday life. I work with many disabled people who could benefit from communication aids but as yet there is no funding in place to buy these. they are unable to work due to having multible disabilities. people are feeling left out and isolated. to not consider adaptations would be a gross misconduct of human rights of that person and any aid or adaptation should be taken into account if it benefits that person</p> <p>9) i think this goes back to my pervious statement of how a claim form should look. an one off assessment doesn't seem right and many disabled people feel this doesn't work. self assessment is difficult specially when the questions are in a negitive way. a diary of things a disabled person would be more benefital. it would be nice if there where key points to consider. as i have already stated reminding the claimant just what activities are likely to benefit them. breaking these down into much simpler questions would make sense</p> <p>10) this is quite a simple question but one which has been ignored for quite a long time. the</p>

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	<p>reason being is benefit fraud. there is only one person who knows there disability the best and that is the disabled person themselves. I understand the need to seek additional professional evidence but to be frankly honest its meaningless. I rarely see my GP and the OT assessment I had before starting work wrote what I told him to write as he didn't have any idea just how my disability effected me. of cause I told him the truth but work again questioned this saying they did not feel the assessment was a true reflection of my abilities or disabilities. they felt I wasn't being truly honest and making out I could do much more than I can. every assessment is subjective unless you spend time with that person on a daily basis. so what ever you do you will always be open to subjective views. this however doesn't take away the right of the person themselves they know their own disability better than anyone. if an interview is needed for some claimants then this is a good idea.. after getting turned down for DLA 3 times I went for a medical assessment who even after looking at my claim form couldn't see why I was rejected</p> <p>11) the problem with being assess by a health care professional is many disabilities are very unknown and it would be impossible for anyone just to know how a disability effects a person. as I have already stated my OT assessment didn't know just how my disability effected me and on this note his assessment from my employer was turned down saying it was too subjective. it is clear that I need additional help and this is sometimes the case with visible disabilities but disabled people have many hidden disabilities. working for a charity who supports deaf peolpe in the community they felt they had a greater understand of my deafness than the OT assessment I had, this much is true. am I saying there should be different people assessing people? No this would be impossible to do. I have many impairments there is not one person in the UK and believe me when I say I have looked who can fully understand just how I am able to do much as I can considering my impairments. this is why I do not feel that an assessment based on medical grounds is a good idea. nore is an assessment based on ability that day. my OT assessment at work was carried out in the summer as I have already said I am much worse in the winter. it was also carried out in a quiet room making it much easier for me to hear. considerations even a professional OT did not take into account</p> <p>12) under some circumstance yes this is a good idea and a follow up would be need but with most disabilities only getting awarded to those who have live long disabilities I don't feel this is needed. I am at yet to meet anyone who have been awarded DLA unless by a faulty claim who situration has changed. if this is because you are going to change awards made to short term disabilities this would be a good idea but it is clear you are not and a person will have to be disabled enough for over a year to claim PIP so feel this is a waste of time and effort causing additional stress to the disabled person having to go through all the process again justifying things still haven't got better. if it is awarded for life this should mean as much.</p> <p>13) this question is so conratictory to your last question and is quite insulting. as you have already stated changes to a persons circumstances can change over time without the person knowing. I have no idea what I wrong on my first DLA claim I know I still need help. do I use my wheelchair as much as I used too now. the reason being I now have DLA I have a car I where as before it may take me a whole day to get to shop in wheelchair now I am able to walk the short distance to my car and drive. walk the short distance to the shop and get my milk for my breakfast. could i done this before I was awarded DLA? has this made me more able because I can now get to the shop in 30 minutes and not half a day? in a way yes it has. has my disability improved? No take that DLA away from me am I more able to get to the local shop NO. I feel more able now than I used too I can even work now. could I done this before recieving my benefit?!? has it made my disability better?!? No. these are all changes in my circumstances. the fact I can now walk a little bit more before my claim hasn't mean my disability got better. question is only there to catch benefit cheats sometime which shouldn't happen if you assessed people correctly in the first place</p> <p>14) one of the main reasons for me claiming DLA was the additional benefits it gave me reduce council tax or reduce rates at my local services. the other main reason for my claim was for my mobility car. I already knew getting around was difficult for me but in order to get this mobility car I had to jump through many hoops just to prove that I needed that support. even after getting my DLA I found it very hard to know just what benefits where open to me and just want services I can get. I am still shocked when I tell people I need help and state I have high rate DLA so therefore I need assistance with some things they just look at me and say what? it frustrates me that I having to go through more assessments by OT just to provide evidence of my disabilities allowing adjustments to</p>

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	<p>work. I understand when I first applied for DLA this would mean the end to the countless assessments but this not the case. if any new benefit system is put in place it needs to include all areas and services linked to that person. so if my claim form says I am a wheelchair user I shouldn't need to prove to council that I need a place that is suitable for a wheelchair. at present I am having to rent privately to provide my own living as my award of DLA does not give me any help with this.</p>
ONLINE338	<p>1) Disabled people need to be given incentives and support in order to find a job which in turn, would help them, especially people who suffer depression and anxiety.  5) Definitely not, I know of one person who was able to get her child on DLA because her son is hyperactive. I now know of other people upon finding this out have subsequently used the same condition to get their children on DLA. In Northern Ireland especially this benefit is a joke.  11) This brings with it a possibility for a difference of opinion depending on who examines you. HCP's can have varying opinions as is clearly seen from the standard of examinations for DLA.</p>
ONLINE339	<p>1) The main problem is the attitude of none disabled people, employers who won't employ us because they wrongly think we will be a problem, we will always be taking time off (and won't accommodate us when we need to, for hospital appointments etc) and they think we won't be as committed and work as hard as an able bodied person, when in fact the opposite is true, disabled people are the hardest working people and will put more 'effort into getting the job done' because we feel like we have to, we will,  The wider prejudice towards disabled people in this country (not least from the coalition government itself) is another barrier to us living full independent lives, and the lack of understanding about the real effects of disability is another. the government talks about giving us that independence and chance of a normal life whilst at the same time taking from us everything that helps us live a normal independent life, like DLA, without DLA, or the new benefit, I just will not be able to live, far from being a barrier to work as the blatant lie in this document states, DLA HELPS disabled people to find and stay in work, and be independent. without it I won't have a hope in hell of working, how do I get to work without a motability car paid for through DLA? how do I get any adaptations to help me in the workplace, or at home without DLA? without DLA or PIP I will be housebound, not able to go anywhere, do anything, I might as well be dead and am already considering how to go about this, and let's be honest, the government wants that for disabled people don't you, no need to help us when we're dead is there. I can do things, I can be independent and work and drive an adapted car, but not without DLA or the new benefit. I need the extra financial and personal assistance those benefits offer to be able to live, I'm not asking for handouts, I'm not a scrounger, I just need help to live a normal life of the sort everyone deserves, the proposals in this consultation will take that away from me and many thousands of others like me, how can you say being in a wheelchair is not a disability? that's basically, reading between the lines, what you are saying, and yet any sane sensible person would say not being able to walk is one of the most severe disabilities there is, wheelchair or no wheelchair. I'm young, I can push my own chair, but not all the time, I get tired, I ache, sometimes I need help, to say I don't need a disability payment because I'm in a wheelchair is nothing short of sick and evil.  in short, the biggest barrier to a full independent life that disabled people in this country face today is the coalition government. I'm a wheelchair user, so I won't get PIP will I, well, that will be my life over, and I had so many plans for myself too, things I could have achieved before this, still I will die knowing my death will be on your heads for a long time to come, that's if you actually care at all, being conservatives I doubt you will.  1) Lack of understanding (mostly from the coalition government) about the needs of disabled people regarding their ability to lead a full active life, for example, I NEED DLA to do just that, without DLA I am housebound, to get a car, which to me is not just A to B, it is prison cell to paradise, motability is the only way I can do that.  lack of access to jobs,  prejudice, thinking disabled people will be less reliable in the work place than able bodied people etc.  People (again see government) thinking they can just treat us any way they want to and we won't fight back, well let me tell you, WE WILL.  2) I will start by mentioning one thing that, to be fair, I think should change, i.e. the motability car you are entitled to through higher rate motability (which I get, also middle rate</p>

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	<p>care). currently a 'customer' gets the car for 3 years, i actually believe this is too short and should be more like 5 years, my parents, friends, and other relatives have never owned a particular car for less than that.</p> <p>now, what shouldnt change, the entitlement to DLA of wheelchair users, i think the proposal to not allow wheelchair users to claim PIP is nothing short of sick and evil, i have spina bifida and use a wheelchair permanently but the fact that i use a wheelchair does not mean i am independent and always mobile, im always with someone, and sometimes i get tired and my bones ache so i need a push, being a wheelchair is far from as ideal as being able to walk and this proposal to stop payments to wheelchair users must be scrapped now!!, it will not help wheelchair users to work and live a normal independent lives, it will have the exact opposite effect.</p> <p>payments should stay at the same level, evewn with DLA and working a lot of disabled people still live below the poverty, or at least what should be seen as below the poverty line, so to lower it would just make things worse, im not sure yet of my opinion on having less 'levels' of payment so i wont comment on that yet.</p> <p>3) wheelchairs, now, you will say NHS wheelchairs are free, but im young and want to look as good as i can and NHS 'tanks' as i call them dont fit into that. so through the wheelchair voucher scheme and the generosity of friends and family i buy my wheelchairs.</p> <p>travel costs, to hospitals and things like that</p> <p>heating, disabled people feel the cold much more than able bodied people do but that means higher bills</p> <p>clothes and shoes, i struggle to find shoes that fit well and sometimes have to pay more, again,i want to look good so refuse to wear orthopaedic moon boots. but i suppose you'll say i should.</p> <p>household wear and tear caused by the wheelchair</p> <p>some surgical dressings</p> <p>3) travel, adaptations (including wheelchairs) extra medical equipment not readily available on the NHS, special dietary products not easily available</p> <p>There are many extra costs and DLA is essential to cover those costs.</p> <p>4) yes there should be that option, i use my DLA to partly fund the purchasing of my wheelchairs.</p> <p>5) YES, in big neon 100 feet high letters with bells on YES YES YES and even more YES. Anyone with a severe lifelong disability should have automatic entitlement to the benefit, one of the strangest things about DLA is that it is called Disability Living Allowance and yet some genuinely disabled people havent been able to get it, or have had it removed because they can pick up a coin or something,and live in fear of losing it at any moment, that is just ridiculous, a disability is a disability pure and simple, no matter what your level of ability is despite the disability. there is a guy in America who does a form of BMX'ing, jumping ramps and things, but in a specially adapted wheelchair, Aaron Fotheringham, he can be found on the internet, he can do that, and he can drive,and be independent, but he is still disabled, same disability as me in fact, still needs help and assistance, and if he lived here should be entitled to the benefit no matter how high his ability is. if youre genuine, you should be automatically entitled, no questions asked.</p> <p>6) working, getting out and about, taking part in activities,The fact that someone is more severe than another is neither here nor there, we are all disabled, The only thing you should ensure is that non disabled people dont get the money, only the genuine, no matter what level of disability</p> <p>8) no, I dont care if someone has bionic legs, a'la the \$64million Dollar man, they are still disabled, that should be all that matters. having a wheelchair does not mean im less disabled because i can move around in it, its still not easy, and to propose to not pay the PIP to wheelchair users is just plain wrong,</p> <p>8) NO, NO in big neon lights, NO NO NO</p> <p>the fact that i have a wheelchair does not make me more independent, quite the opposite, i still need a push in the chair when my arms ache, i still need pushing uphill (and by uphill i dont mean ben nevis, i mean any road at an angle</p> <p>It is not aids and adaptations that makes a person more independent, it is the thing that gets them those aids and adaptations, money, DLA,</p> <p>To not give the new payment to wheelchair users is a disgusting proposal, is the wheelchair not the symbol of disability?</p> <p>9) Dont confuse with jargon, use plain simple english, Dont spin, Dont twist words to deliberately try to get the claimant to fill in the form in such a way as to lose them their right</p>

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	<p>to help, dont deliberately try to confuse, be clear and concise.</p> <p>9) as for part two of this question, just simply make it more available, people have to go looking for needles in haystacks to find out what they might be entitled to. be plain clear and simple. but not necessarily shorter, that just means relevent important questions are being left out.</p> <p>10) for one, in my case my medical records that by now are probably the same size as the collected works of shakespeare. evidence from my GP, and consultants at the hospital who ive been seeing for several years, evidence from people that know me, and know what i am and am not capable of. family, friends, anyone ive had a long term connection with, people from relevent organisations i attend (like the link centre in Oldham) basically as much supporting evidence as possible and it MUST be taken into account,me turning up to a medical and talking to someone i dont know is just not enough, or fair.</p> <p>10) medical records GP's, hospital consultants, podiatrists, family, friends, people that have known us for years in most cases. But most importantly, the applicant MUST be listened to, i know the most of anyone about myself and my ability and how it affects me on a daily basis, and contrary to popular belief about benefit applicants i would not lie just to get a bit of money, i am 100% genuine</p> <p>11) the (ATOS, lets be honest, its them) 'professional' wont know me and will only have a basic (if that) understanding of the effects of my disability) and obviously will be up for a bonus for making the right decision (according to the government) that is just not right and must be stopped. someones bonus could ruin a life. the health of the applicant, ive heard of someone who had just come out of a coma being questioned about this kind of thing, that is inhuman. also, the ability to get to the interview, some disabled people cant travel far.</p> <p>12) number one, and most importantly, some disabilities, like spina bifida, just arent going to improve, only get worse, those people with this kind of condition should have one medical, and have the results put on file and never bothered again, unless they want to look at doing more. but thats their decision, constant reviews, constant threats to a persons life line, causes major distress to that person, and means they can never relax and be allowed to just get on with doing something with their lives. and to do that to someone, particularly a good decent genuinely disabled person is wrong on so many levels. yes, if their is to be reviews, they should cater to waht the applicant can handle, as for frequency, no less than every 5 years, if at all.</p> <p>13) the only reason genuinely disabled people dont report changes is that they think they will lose their entitlement if their circumstances have changed and just cant bear to go through the process again or deal with having less money, so they are scared to say anything. A guarantee that a claiment wont lose out for being honest with you is the only way to get more people to report changes, and then for you to follow through on that guarantee.</p> <p>15) i think, as is my case, most applicants already access advice and support, but that was my choice so i dont believe it should be a requirement, that kind of thing still smacks of 'nanny state' and i thought the coalition wanted to get away from that.</p> <p>16) yes there should be that option, DLA used in that way helps and so should PIP i currently fund my wheelchair buying through the wheelchair voucher scheme and the kindness of others.</p> <p>?) very useful, the fact that my mother can get carers allowance because im on DLA is of vast importance. without that she couldnt cope, and the thought that as well as losing DLA or not getting the PIP, my mother would lose carers allowance is extremely upsetting to me, she is a wonderful person who basically gave up her life to help me and should be rewarded for it. she just couldnt manage with the loss of my DLA and her carers allowance</p> <p>?) we would have less life options, simple as that</p> <p>?) all assessments should be combined, it is not fair to put disabled people through medicals and assessments all the time throughout life time and time again, a one off assessment covering everything is all thats needed its fairer to us, and cheaper to you. Medical notes from GP's and consultants could be shared, some would have a problem with that, i dont think i would, its better than constant medicals and being interfered with, i just want to get on with life the best i can</p> <p>?) All of it,</p>

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	<p>let me be clear, i am not saying there are not people claiming DLA who shouldnt be, there are, and they need to be found, but they are comparatively very few, less than 1% of claims are fraudulent. and if they were found it would mean more for the genuine, but this is hitting the genuine more than the scroungers!!!</p> <p>DLA helps me live a life, gives me my life, without it i Have nothing</p> <p>?) yes, any genuine lifelong disabilities that are never going to get better should have automatic entitlement.</p> <p>for example i have Spina Bifida, im probably midway up the scale of severity of spina bifida, I cant walk and use a wheelchair permanently, I WILL NEVER GET BETTER, i very much doubt i will wake up tomorrow and miraculously have gained the ability to walk, i will only get worse, as i have. people with these kinds of conditions should not be put through these medicals, just check our medical history and talk to medical people we are involved with. my medical records are probably around the same size as the collected works of shakespeare, im sure any relevent information about my disability can be gleaned from them.</p> <p>?) getting around (motability car) as ive already stated its not just A to B when a disabled person has a car, it is real genuine freedom.11) getting there, and the personal opinion and agenda of the consultant, particular where the payment of a results bonus is concerned.</p> <p>?) getting there, and the personal opinion and agenda of the consultant, particular where the payment of a results bonus is concerned.</p> <p>?) as little as possible, why should genuine people constantly be subjected to degrading medicals all their lives?</p> <p>yes, there should</p>
ONLINE340	<p>3) I have MS. I spend four times my DLA each week on the following: Pilates sessions ( £30) to retrain my feet to pick up so I do not fall so easily, a cleaner as the fatigue is too much for me to stay on top of my housework ( £40), payments to run my car as on a bad day I cannot walk more than 100 yards and ready to cook meals as again the fatigue prevents me from cooking a meal more than a couple of times a week. The only reason I can afford any of this is my hard working husband manages to make a "decent" living of around £48k a year (not huge when one lives in London).</p> <p>Everything is much harder when you are disabled. And most people spend far more than their DLA on the extras they need.</p> <p>9) It's the process of telling someone how bad you are that is so negative in the form filling process. When I had to do my form If felt very upset afterwards. I wanted to kill myself (and I am not kidding) as the full realisation of my situation (sleeping several hours many days a week, not being able to work, or walk far, bowel incontinence, falls, etc) made me feel useless. Even listing it to give you an idea has made me feel really bad.</p>
ONLINE341	<p>5. As an M.S sufferer I feel that some health conditions should have automatic entitlement because some illnesses and diseases are always underlying and can emerge at any time. To review entitlements, dependant on needs, would mean having to submit paperwork, face to face interviews etc on an ongoing basis dependant on frequency of illness/disease, surely this would be costly,time consuming and cause confusion as to when an award should come into effect or be terminated? Over/underpayments would result, I am sure.</p>
ONLINE342	<p>1) For mentally disabled they do not have the same perception of the world, of danger and how to fend for them selves including making a cup of tea, let alone going to work.</p> <p>2) benefit should be paid immediately upon application approval not after a waiting or long consultation period</p> <p>The criteria of who is applicable should be similar to the current DLA process</p> <p>3) Therapy, transportation, care incl night time care, special needs equipment, on going costs for the equipment e.g. annual maintenance, replacement parts, batteries etc.</p> <p>4) Increased buerocracy</p> <p>harder for people to understand which rate they qualify for</p> <p>harder to prove which rate you deserve</p> <p>more evidence needed to prove the rate you deserve</p> <p>increase in border line cases and disputes</p> <p>Loss of faith in the system#</p> <p>5) Yes, but this is not just based on condition or diagnosis but on ability e.g. someone who cant speak, wakes during the night etc.</p> <p>6) prevention of danger, activities of daily living, communication and mobility</p> <p>7) Inflation linked</p>

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	<p>When the rate is awarded objectives and abilities should be defined that that rate is to achieve.  These objectives should be measured annually and if the rate can not meet those objectives it should be reassessed.  8) Yes, it should consider anything the benefits the immediate and long term development and benefit for the recipient.  9) Any claimant who is already part of the system and is known, should automatically be awarded. I.e. if your PCT / social workers / doctors etc already know about your situation you should automatically be submitted for the benefit.  Make it simple and clear.  The form should be guided and medical / therapist reports should be submitted as evidence.  ?) Currently the receiving of DLA is to some level proof of a certain level of disability, this is a key qualification criteria to other benefits and incentives.  IF this is removed then every time a disability item needs to be qualified a whole new process burdensome process is needed. E.g. Blue badge applications.  ?) speedier application process  any assessments that are needed should be done as a priority  greater sensitivity to the case  include all equipment costs</p>
ONLINE343	<p>2) the amount of money paid, my son is 14 and has 6 disabilities including cerebral palsy, registered blind, severe epilepsy, right hemiplegic and being in a wheelchair, we get high rate mobility and care for him, we need it to pay for a wheelchair access car to get him around, as he's too heavy to carry into a normal car, and the care element every week 3 nights out of 7 he only sleeps 2-3 hrs a night due to epilepsy  3) biggest cost is mobility car, my son, s in a wheelchair so we need a wheelchair converted car to get him around, he's too heavy to lift in a seat of a normal car. also had to spend the money on things in our house, had to build an extension with specialised bathroom for him, which we will be paying off for years to come, and also other adaptations, also we will have to pay for a lot more respite care in the home when he leaves school as it will be harder as he will be home 24/7, so money to pay carers wages and take him out on day trips with carer to get him out the house as he'll be bored  4) too fine a line in deciding which is which, i believe you're considering NOT awarding mobility if person is in a wheelchair, my son is in one, but can't propel himself as his right arm is weak, so he goes round in circles if he tries so someone has to be with him at all times when he's out in wheelchair  5) i think visual impairment and behaviour problems should mean entitlement, to little scope then if it's just individual needs  8) not really no my son only uses a k-walker and wheelchair, but had to have mobility car adapted with a lift to take a wheelchair  9) we fill it in for our son as he can't read or write (he, s 14) to many questions in last one were repetitive  10) letter/assessment from local gp and any hospital specialists, also in my son, s case a report from the school, all these things combined would be best as he won't accept a strange doctor seeing him either at home or somewhere else  11) my son, s autistic and hates change or strangers, he lashes out and hits, bites and throws things if upset, best if just get reports from gp/specialists and school or getting own gp to see him  12) for cases like my son who's autistic, the school and his gp/specialist should be consulted instead of a home visit or face to face with a stranger. yes different types of reviews for different individuals. in my son, s case his condition will never improve so frequency should be 3-5 year gaps at minimum  ?) my son, s condition will never improve in his life time  ?) our biggest expense was wheelchair access car, but we also pay for respite care, and things for him to use at home, so NO one of wouldn't help  ?) think it's a ridiculous situation and should stay as it is</p>
ONLINE344	<p>1) one of the main problems is the unpredictability of pain levels and the vast scale of fluctuations that exist between being totally immobilised and debilitated and partially active or mobile but experiencing significant pain. it is not only the physical effects of pain that need to be considered but the psychological affect of pain on wellbeing, concentration,</p>

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	<p>cognitive and memory function etc. significant is the transient yet significant effect of analgesia and medication. understandably, many employers will not tolerate the unpredictability of physical and mental health conditions where they have vastly fluctuating affects on the ability of one to carry out the functions of their employment. However one looks at the problem, disabled individuals are rarely able to live fully independent and active lives, it has to be a best fit on a day to day basis, unless ones condition is deemed to be permanently stable and non fluctuating.</p> <p>2) DLA is not a benefit !! it is an allowance paid to the individual to assist with the associated costs of having to live or exist with a disability. this concept is paramount to maintaining the psychosocial wellbeing of claimants by helping to reduce the stigma that many feel by having to claim benefits</p> <p>3) some of the main costs are associated with having to make decisions or choices at very short notice due to the fluctuating nature of pain and disabling conditions, this is usually associated with extra costs, i.e unplanned travel, unplanned social support, unplanned additional care needs etc. services that are demanded at the point of need are usually more expensive than those that can be planned well in advance. many disabled individuals live daily by having to be reactive to the immediate demands experienced as opposed to being able to plan proactively. additional costs are faced with fuel consumption relating to the need for higher levels of heating and hot water which relate to reduced mobility/activity and increased environmental hygiene demands etc. fully able individuals are generally self caring and efficient, disabled individuals usually need to pay for assistance from significant others in meeting their daily demands</p> <p>5) simplicity appears to be one of the more difficult concepts for organisations to grasp. it make sense for individuals with well defined disabilities to be able to make fast track claims to DLA, this would also reflect a lower claim processing cost to the department. if there is going to be a 2 tier level component, then there is no way that you can differentiate between the vast differences of impairment and pain suffered by individuals with the same condition or disability. there is a really big problem with individuals facing up to their disability and the inexorably linked physical and mental limitations, it is an automatic response for most people to play down their weaknesses and frailties when talking to others.</p> <p>6) this is a very difficult question to answer, as what is important to some individuals will attract a lower priority to others. the whole concept of providing an independent personal payment is surely in the name...the individual prioritises their own needs in direct response to their daily fluctuations. personal priorities do change on a daily or even hourly basis. if the department wants to truly provide independence, then you need to trust the individual to make the choices that will provide the desired level of independence to them when they want it</p> <p>13) one of the reasons that many claimants do not keep the department informed of changes in their condition is because they receive very little information on what and how changes can affect their current benefit or allowance award. at the risk of increasing paperwork, a comprehensive list of the type of changes that will affect specific benefit entitlement should be provided, this can serve a dual purpose of benefit increase as well as decrease</p> <p>?) all individuals applying for PIP's would benefit from the OPTION of applying for a comprehensive and indepth assessment of their need for aids or adaptations that could impact positively on their daily lives. Most disabled individuals are not aware of the existence of Disabled Facility Grants or Direct Payments because local authorities do not advertise or publicise them as government funds are not ringfenced. perhaps a PIP award should be accompanied by a comprehensive document outlining ALL the additional support available to the individual. This would of course need a quantum shift in the departments stance from that of Assessing entitlement on receipt of claim, to advising of ALL potential entitlement relating to the individuals personal circumstances and condition</p> <p>?) some time ago, the department decided to adopt the 'one stop shop' approach, this approach underpins the 'passporting' concept whereas an award of one benefit is an automatic passport to another, this concept saves a phenomenal amount of time and expense in applying multiple assessments and duplicated back office costs.</p>
ONLINE345	<p>1) There are multiple problems, especially for people with mental health conditions.</p> <p>1) Stigma and stereotyping - faced constantly, it leads to humiliation and therefore stress. Because people label the mentally ill they often do not listen to us, they also ignore the</p>

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	<p>things we say and make services etc. difficult to obtain.</p> <p>2) Mental health conditions, like mine, are episodic. Because there are periods when the illness subsides, it is possible to build up your life again, and even to obtain a job. However, because the illness reappears, roughly every three years, we face the loss of everything we have built up in the good times. It is difficult to plan for the future, and build up a good sustainable income and lifestyle, good relationships, and care for those you need to care for.. Quality of life is an on and off situation.</p> <p>1) Stigma, stereotyping and labeling the disabled, particularly mental health sufferers. We are treated with suspicion, sometimes contempt, and sometimes as if we are faking it, and sometimes as if we are weak minded and pathetic. This prevents us from getting good jobs, good services and also impact upon our family lives.</p> <p>2) For people with severe mental health problems, the payment should be awarded indefinitely - in the same way as DLA. For example, I suffer from Affective Schizoid Disorder which has periods of psychoses lasting for approximately 2 years. This is a period where a severe psychotic state occurs and then treatment is given in Hospital. However, during the treatment phase and post treatment, the inability to do things for oneself lasts for at least two years and more in a severe form, and then less severe later. However, the period when one is free from the illness is very short - usually about a year. The bouts of psychoses emerge every two to three years. During these periods, it is impossible to keep appointments - such as a review for benefit. It is impossible to attend to letters and matters of personal concern. Until my DLA was awarded indefinitely, I often lost out on benefits.</p> <p>3) As a person suffering from Affective Schizoid Disorder, main costs are:  the need to have someone to do your shopping and cleaning in the house.  The need to have access to one person who can manage financial affairs, and affairs of personal concerns which cannot be managed in a lengthy period of psychoses. Social workers etc will not do this, and they do not have the expertise to do it, they also feel they should not have to do it, that it is not part of their job. Support workers can do part of it, but in my case I only had access to a support worker for 1 hour a week.  The need to be able to go out and visit people, friends etc so that you can keep in contact with the real world.  The need for social activity and occupational activity, so that one has activity to occupy one's time and keep one stable. Such as attending local educational classes, developing hobbies. The need to have somewhere to go, that is social.  The need to have someone to remind you to be more social, to wash regularly. To have someone sympathetic who can help you stave off fear, depression and confusion.</p> <p>3) People with mental health problems face extra costs of:  1) Trying to keep their health and home clean, tidy and running well so that they do not lose it.  2) Mental health sufferers often need some form of activity that is social and practical to ward off depression and stress. This incurs extra costs because they have no choice about this, since it is a need and not a personal choice.  3) Mental health sufferers often have other illnesses or conditions that need attending to, the mental health problem complicates this and adds to the burden of being healthy and fit.  4) Yes, having two rates is good. Some people are disabled and find things difficult however, they are not severely disabled. Therefore two rates is cost effective and will be easier to understand if the differences are explained clearly to claimants.  For people with mental health problems that are severe, it needs to be ensured that the descriptors in the higher rates of payment are suitable for them. In the past, DLA higher rate mobility component has largely been unavailable to those of us with severe mental health problems, because the DLA focuses largely on the medical model of ill health and disability. For example, for us, it is not safe to be mobile in some circumstances (driving a car, walking in traffic, attending to tasks such as cooking etc.) This severely limits our mobility, especially in rural areas. It affects our abilities to look after ourselves because what we need is normal life to bring us back around to good mental health. This incurs extra costs - for example, paying someone to take you in their car to such and such a place - this is very true if you live in rural areas where public transport is limited and poor.  5) In the past, those of us with severe mental health conditions have been at a disadvantage because there is a big emphasis on physical health in claiming DLA. To have a more individualised approach is fairer, and provides assistance where it is needed. However, there must be some general guidelines.  6) In terms of severe mental health problems, the most essential activities for everyday life</p>

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	<p>are:</p> <p>The ability to have three meals a day</p> <p>The ability to keep oneself, and one's home clean</p> <p>The ability to manage personal concerns such as:</p> <ul style="list-style-type: none"> <li>deal with the post,</li> <li>manage demands of officialdom,</li> <li>interact with officials regarding one's home e.g. paying the utility bills, paying the mortgage/rent, paying council tax.</li> </ul> <p>dealing with complaints and complicated queries from others - such as a neighbourly dispute, or catalogue payments, or hire purchase on the car etc. etc.</p> <p>The ability to maintain social contact with one's friends, to visit them and go out with them.</p> <p>The ability to maintain a hobby or interest.</p> <p>The ability to attend medical reviews and appointments.</p> <p>The ability to improve one's condition, whatever that may take.</p> <p>7) For people with severe mental health problems, the fluctuations are of the nature that inability to cope, lasts for at least two years in a severe sense. The ability to cope then might reappear for a while, but even this period is fraught with difficulties. I believe that mental health patients should be able to report their fluctuating conditions to either:</p> <ul style="list-style-type: none"> <li>* a mental health care worker - who should have a standardized tick form. (because they detest more admin)</li> <li>* a dedicated email system.</li> </ul> <p>This would enable patients to describe in detail how things have changed and it also registers a change formally with the least of complications. In addition, both parties have a copy of that report. Which is often important for mental health patients because we are often accused of not filling out forms correctly, or not delivering the forms to the correct address or person. Getting evidence of our report often involves photocopying, registered letters etc. These are expensive, time consuming and too complicated a process for us.</p> <p>Also, if we have an email system we can correspond with less stress and less expense. We would have less problems with form filling, language, and would not need to co-ordinate ourselves so much. It is difficult to</p> <p>attend a meeting at the CAB etc, and this produces extra stress for us at a time when we are at our lowest.</p> <p>Phone calls take too long, and are correspondingly expensive on a mobile phone. (which most of us have instead of a land line) They are sometimes chaotic as well, and it is difficult to remember what was said. Patients without access to email at home can use a phone, or attend the library for free access to email, or perhaps attend their local MIND charity premises.</p> <p>8) Aids and adaptations are the type of assistance which normally implies a physical disability. however, many mental health patients need aids and adaptations of the sort that help them to take part in routine life. For example, obtaining and working in a job can be difficult because the mental health patient might have trouble concentrating for long periods of time. An aid would be the ability to take breaks from the work - for example, being able to turn away from the computer and occupy oneself in something else, that is not work related for five minutes. This would reduce stress and diminish the fear that stress might induce the illness again. Having flexi time is also good - enabling the worker to fit employment around his/her illness. Being given the opportunity to drop in and out of</p>

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	<p>employment without fear would also be good.</p> <p>9) The best way to communicate with people who have a severe mental health problem is to:</p> <ol style="list-style-type: none"> <li>1. Cut out all jargon. Everything should be explained in simple language, even if it takes longer to write in that way.</li> <li>2. Don't have questions or pages that say "refer to page so and so, or question so and so. take the time to repeat that page or question or whatever. Otherwise it is confusing.</li> <li>3. Have a separate set of questions for each disability of a similar nature. For example, have a set of questions for the physically disabled and a set of questions for people with severe mental illness. Otherwise it is hard to work out what is relevant to you and where you can put in what is relevant to you.</li> </ol> <p>Information about the new benefit: To be included on the application form and leaflet.</p> <ol style="list-style-type: none"> <li>1) Leaflets and t.v adverts are best.</li> <li>2) Put key points in bold characters in bullet points</li> <li>3) Tell us who who does not qualify for the benefit, in clear terms.</li> <li>4. Include a front page, jargon free, of the key principles behind the benefit. i.e. based on the social model of disability, intended to remove barriers so that the disabled can work. Otherwise we don't really know what we are applying for.</li> <li>5. Provide the payment rates for the benefit, so we know what they are without needing to enquire, or get a different leaflet or wait until we hear from you.</li> <li>6, Give us an easy way to inform of changes to our condition - other than phoning. Provide a form on the benefit application pack, and an email address we can use.</li> <li>7. Put all of this on the application form.</li> </ol> <p>10) 1) Medical evidence from G.P.s and Consultants 2) Evidence from personal support workers 3) Evidence from the applicant</p> <p>11) 1) The benefit with face-to-face discussion with a healthcare professional, is that professional G.P.s and consultants are aware of all the plethora of disabilities and constraints that being disabled brings about. However, psychiatrists tend only to be interested in the florid symptoms of the illness. They tend to diminish the other symptoms that occur during recovery and those that degrade quality of life. (Such as side effects of medication, like restless leg syndrome and the terrible lethargy that occurs with heavy tranquilisers.) Healthcare professionals should also be independent of the applicant's G.P., social worker etc. This is because in many cases a person with severe mental health problems may not have a good relationship with the mental health team caring for them. This can be quite common.</p> <p>2) It would be inappropriate for a health care professional to have a face to face meeting with a disabled person if that professional did not have a well grounded and well rounded understanding of all the problems that a disabled person has to face. This is especially true of mental health problems, where some inexperienced staff pooh pooh the problems that degrade quality of life, because they think that the patient should tolerate side effects of medication if the medication stops the florid symptoms of the illness.</p> <p>12) The type of evidence that should be used to determine the frequency of reviews include:</p> <ol style="list-style-type: none"> <li>1) Whether it is possible to adapt to the disability, so that the disabled are able to learn new ways of doing things that reduce the severity of the disability over the long term.</li> <li>2) There should be different types of reviews according to the needs of the individual and their impairment. The DLA has focused too much on impairment by physical disability and the form was often difficult to adapt to mental health problems. Reviews were similar.</li> <li>13) Give claimants the information they need to report changes. Many patients feel fear when they report a change because they do not know the outcome (in monetary terms) of reporting a change. This then builds up more fear because it is the unknown. If you provide</li> </ol>

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	<p>some approximate figures, the claimants then have time to manage their budgets and also weigh up the consequences for failing to report. Claimants need time to think, and information.</p> <p>14) Yes, it would be beneficial and helpful to provide information and advice as part of the application process. This is especially true for people with poor mental health. A state of mind can vary from day to day, one day the patient might be well enough to make an application for the payment, but the next day might not be so good. Therefore, if the application is a long process of completing the application form, and then a separate process of getting advice, then a separate process of getting information the chances are that this will exhaust the good time available for a mental health patient to apply. Processes such as these take longer for mental health patients.</p> <p>15) For mental health patients, a requirement to access advice and support is damaging to them. Many mental health sufferers are ashamed of their condition, and do not want to reveal it to people who live in the community - this is especially true in rural areas. Confidentiality is important, because quite often people will treat you differently if they know you have a mental health problem. The best way to provide advice and support for mental health sufferers is to let them have access to information and advice without the need to consult an actual person</p> <p>16) Mental Health problems require all sorts of aids and adaptations that are not necessarily tied to physical equipment.</p> <p>17) Children feel stigma very strongly and should need to be assessed in a situation and environment that is familiar and comfortable to them.</p> <p>?) The DLA has been very in providing passports to other entitlements. In my experience as mental health sufferer there have been no passports to other entitlements. For example, for approximately a year after treatment in Hospital I have paranoia about being alone, and need constant company from another individual. This needs to be arranged, so that I do not become a burden to my family and friends. One of the arrangements I have tried to make, is to attend L.E.A courses of education. However, these are very expensive, and D.L.A. does not give the same freedom to join as unemployment benefits. D.L.A does not provide free eye care or dental treatment either. The cost of being disabled because of mental health problems is high, and we cannot get jobs that pay the average wage, because of our health problems. Getting a job is perceived, buy us, as therapeutic rather than financial gain and security.</p> <p>?) Different equality groups obviously have different cultures - these cultures mean that there is a different impact on the individual according to the group they are in. Gypsies for example do not like the idea of disability, especially mental illness. It is a terrible stigma and the reaction is one of horror or mirth or both. Usually, when referring to equality groups, or minority groups, gypsies are not specifically catered for - they are often missing from the standard forms created to measure impact on the different equality groups</p> <p>?) I have never been able to use D.L.A. as a passport to other benefits and services, so the problem would remain the same for me. However, if Personal Independence Payment did provide such a passport it would ease my financial burden considerably and improve the quality of my life.</p> <p>?) The Allowance should be paid for indefinite periods to mental health sufferers because there is no guarantee that they will have a period of mental fitness at a time they need to make a claim, or have a medical review or need to attend an appointment.</p> <p>?) Medical information could be shared - but with strict confidentiality rules. Confidentiality rules should apply to all shared information, and employees using this information need to undergo proper training.</p>
ONLINE346	<p>1) Main problem is still other people's attitudes towards disabled people. Whilst we may think as a Society we have changed our views on 'disability' this is not actually reflected in the many physical and psychological barriers that remain in place. For instance new build shopping centres; housing; public buildings all still have to be altered on completion to make them 'barrier free' this is still not being viewed as a 'baseline' necessity of newbuild properties. Transport - still very few forms of transport are barrier free. Yes the occasional bus will have room for ONE wheelchair but on the whole they are not built with disabled people in mind. Trains - how many stations are still without a lift, or you can access one platform but not the other. Local Government is no longer able to fund Disabled Adaptations or indeed supply all the equipment that is needed due to lack of funding from central government and it is up to the individual disabled person or their family) to try and fund adaptations/equipment, just as they have to fund the cost of a Car/petrol and pay for</p>

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	<p>private domestic help as local authority care agencies no longer carry out domestic tasks.</p> <p>2) As the Government is responding to the ever increasing age of the population by deferring the state pension to the late 60's, I feel DLA should also reflect these changes. Many people like myself try to be as independant as possible from our families and the very thought of DLA care/mobility component being removed is very frightening indeed. A Car is not a luxury but an essential means of transport as I am unable to access bus/trains. Additional domestic assistance is again not a luxury but essential as local government care agency no longer provide assistance with domestic tasks. So therefore suggesting that it be `reviewed` at the age of 65+ is nonesence, I want to remain as independant at 65+ as I do at 63! I have had my disability ALL my life does the Government think it is going to somehow IMPROVE on reaching 65+ or that I shall need less assistance in life at 65+</p> <p>3) When you have a disability EVERTHING in life is more expensive! I have to have my heating on at high 24 x 7 days in the winter as I have poor circulation due to my medical condition (Paralytic Polio), my Bills are huge for both Gas and Electricity. I cannot shop around for best buys therefore my shopping bill is high; I cannot just pop into a high street store to try on clothes in the small inadequate dressing rooms so I shop from a Catalogue or on Line thus incurring additional costs - no bargains there!</p> <p>I cannot make use of reduced bus fares for senior citizens - I cannot access the buses therefore have to incur costs of running a car (which are helped by the Mobility component of DLA) but the cost of Petrol is huge! I have numerous visits for medical appointments and have, on occasions to use a taxi as parking at hospitals is almost impossible. I require assistance with Domestic Tasks and pay a private domestic assistant. I could go on and on and on ....</p> <p>5) I think it would be more cost effective for a person with some specific health impairments to receive an automatic entitlement to the benefit. This would save on assessment costs and cut out a lot of form-filling. ie a who has a spinal injury resulting in paraplegia is not going to make a miraculous recovery; or a person with Huntington`s Disease; Muscular Dystrophy; Paralytic Polio; etc.</p> <p>6) The ability to carry out personal care tasks such as toileting; bathing/showering; food prep. should be looked at - but the assessor must be prepared to see it from the disabled person`s perspective ie they may need assistance with someone running the bath water and emptying it, but wish to bathe privately; they may require to fund (from their DLA) the installation of a Step-in Shower as they can no longer access a bath using equipment (LOCAL GOVERNMENT NO LONGER HAVE FUNDS TO ASSIST WITH MAJOR ADAPATIONS) also a Stairlift may require to be purchased from their DLA so that they do not have to sleep in the living room or dining room as their internal stairs become a barrier. Assistance with food prep/cooking and not just reliant on precooked frozen meals. Assistance to dress.</p> <p>Mobility issues result in a car being essential or if the disabled person cannot drive then to be able to afford to use Taxis. To be able to heat ones home to a comfortable temperature as meets the disabled person`s needs. To be able to go out and socialise (with assistance if necessary).</p> <p>To have choice in life as everyone has to live an independant life and choose fro where you purchase the necessary assistance and not be reliant on a Local Govnment Home Carer who pops in for two minutes; keeps their coat on whilst helping you to toilet or have a frozen meal shoved into the microwave for two minutes and served from the carton - yes it does happen unfortunately and no matter how many times one complains you are only told that their are just not enough carers to go around!</p> <p>7) A bi-annual assessment could be arranged for fluctuating conditions, and an annual short appraisal could be given by the Consultant/GP if thought necessary.</p> <p>9) Health Care staff ie GPs; Physio`s; OT`s; DN`s really need to go on courses to have an understanding of DLA (or tne new proposed benefit) as they have very little understanding of it or the complexity of the form they are trying to complete. The existing form is too repetitive in its questions and needs simplified for the disabled person to complete and state exactly what areas they need assistance with in their own words rather than tick box after tick box. The professional aspect should be on the medical condition as the health professional usually has very little insight into how the disabled person manages at home as they very rarely (if ever) visit them at home.</p> <p>Information could be provided on every discharge from hospital; be held in every hosp. waiting room and GP surgery and also in Libraries. and written IN LARGE PRINT!</p> <p>10) Many GP`s have little understanding of many medical conditions that result in physical</p>

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	<p>disabilities. GP's are, with due respect, basically 'Masters of all trades but Experts in none.' They no longer make home visits or have time to chat with patients who attend the surgery, therefore lack insight into how patients are managing on a practical level at home and in the community. Consultants have a greater insight into the medical condition and its prognosis; perhaps an community based OT or Physio would have more knowledge than say a hospital based OT/Physio.</p> <p>11) As long as the Health Professional leaves, at the door, their pre-conceived ideas of what is 'best' for the disabled person. A person who has lived with their disability for years and years knows what works and what doesn't work for them. DLA financially assists some of the way to fund this addition assistance as should any new financial payment and not be reliant on a 'needs met' care package that is a waste of time and money. I can't honestly see any circumstances where it would be inappropriate to meet with a healthcare professional, but then I do not know of each applicant's private circumstances so could not really judge this.</p> <p>12) I think the criteria and frequency of reviews should be based on the individuals impairment/condition. This would also help cut the costs of monitoring and reviewing. A basic biannual review based on a self assessment form and this could be followed up, if necessary, by a phone call/or personal visit.</p> <p>13) A biannual self assessment form should highlight the importance of individuals reviewing their own needs, therefore they could not honestly say that they were unaware of their needs changing, as they would have personally reviewed their needs on the self assessment form. Perhaps a 'spot check' could be carried out and indeed noted on the self assessment form with an amount given that would be the fine (say £1000) to deter those that are not inclined to be 100% truthful.</p> <p>14) I think it should be made clear that not ALL disabled persons are financially better off using a Mobility Car, indeed some get a better deal using their DLA Mobility component to purchase a small car. Just as the Aids and Adaptations scheme through the local Community OT is no longer that good, yes assessments are carried out by OT's but they lack availability of funds to purchase the aids. A scheme could be set up to enable persons to be able to purchase aids at reduced prices using their DLA. Leaflets sign posting to both Local Government and NHS providers for wheelchair assessments and OT assessments should be included within each DLA pack.</p> <p>15) Large posters in hospital waiting rooms and GP surgeries could be useful. GP surgeries and NHS run clinics should be required to hand out leaflets to individual's say when they call in for their annual flu jag. I dont think individuals should HAVE TO apply for DLA (or similar benefits) some people like to remain financially independant.</p> <p>16) I think a great many people are assessed for Aids &amp; Adaptations and their file just sits in a box for months if not years waiting funding to become available. Whilst others, including myself, use their DLA to fund aids/adaptations within their home to ensure they can maximise their independance and prevent falls. People presently have the option to use their DLA to fund aids &amp; adaptations if they can afford it. Usually in the summer one spends less DLA on heating and therefore can afford to spend the money on an aid or save it up for an adaptation.</p> <p>?) I think that all recipients of DLA and of the Carer's Benefit should be contacted direct to take part in this Consultation exercise, as many may have no access to the internet. I am sure that most recipients of DLA will be like myself, extremely stressed and anxious about the proposed changes to DLA. Our quality of life is at risk, particularly with the downturn in Central and local Government finances, Services which were once available to disabled people have been drastically cut or replaced with much inferior services. DLA, both the care and mobility component do indeed make a huge difference to a disabled person's life.</p> <p>Like many other disabled people, I feel this review is all about the present Government pursuing the people who have abused both the Incapacity Benefit and the DLA Benefit System, however what the Government is actually doing is tarring everyone with the same brush in their pursuit to weed out these dishonest recipients of Benefits and thereby placing thousands of honest disabled recipients under untold stress and anxiety. Should the Government not be looking at the GP's who signed off these people as 'unfit' and question the GP's on their abilities to make judgements? Why why why should it always be the most vulnerable in society that gets made to suffer the worse - this is definately Disability Discrimination made up to look like some new Government Policy!</p>

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	<p>?) Surely in this age of computers one could input data from a homebased PC just as I am doing right now, and this could be used to populate info into other assessments therefore minimising bureaucracy and duplication.</p> <p>?) I'm not sure, as DLA does not appear to be a passport to other entitlements, or at least it is NOT signposted as such.</p> <p>?) You should take into consideration that an older age group does not like to feel they are "Begging" for additional monies, neither do disabled people want to feel that they have to embellish their disability to `convince` the assessor of their needs. So therefore the protocols on which the assessments are based should be safe guarded not to alienate any group of society whether by the wording used or by the questions asked.</p>
ONLINE347	<p>1) Old buildings and ineffective laws. For instance, there is a 'community project' being built in my home city that is being put into a two storey old building, with a cafe on the first floor, accessible only by stairs. This will exclude many people, but the usual phrase 'reasonable adjustments' is being used to excuse the project from including the whole community.</p> <p>3) It depends on the nature of the disability. Many people are able to stand or walk to a varying degree. This can mean that a person in receipt of Mobility Component who can walk can access a car, bus or aeroplane, whereas a person confined to a wheelchair would have much more difficulty with this and therefore their general ability to get around whether for business or leisure is restricted. The same applies to the structure of buildings. People who are confined to a wheelchair would need to pay extra for help to access special facilities or general facilities where they are inaccessible to them.</p> <p>A vast array of specialist equipment available to disabled people at extra cost and more so with the more severe disability. For instance, a simple hand rail can cost a few pounds whereas an outdoor powered wheelchair costs thousands.</p>
ONLINE348	<p>1. Barriers include</p> <p>1] Finding jobs which they can do, or, which can be adapted to 'fit in' with their capabilities</p> <p>2] Employers and general public perception about what disabled people can do, employers/public may not have awareness of the wealth of skills that disabled people have and can bring to the workplace</p> <p>3] Public Transport can be a huge barrier to a disabled person it can prevent the person travelling to a workplace [ if that is the only option the person has for travelling ]</p> <p>4] Money - A disabled person may have to pay more to travel [ if unable to use public transport ]</p> <p>3. 1] Travel Costs - Especially If the disabled person is unable to use Public Transport</p> <p>2] Costs incurred in looking after their own Personal Care e.g help with Feeding, Bathing, Washing, Dressing and Making a Meal</p> <p>3] Costs associated with maintaining a home that is clean / comfortable for them to live in [ i.e if the Disabled person is not capable of cleaning or carrying out housework]</p> <p>4. I personally don't think having 2 Rates for each component will make the benefit easier to administer by DCS Decision Makers [ there are already 2 components for Mobility and just 3 for Care ], however, it may simplify it somewhat so the Customer can be clearer on how to qualify for the components</p> <p>5. In general I agree that the following conditions/impairments should lead to an automatic award of DLA -</p> <p>Severely Mentally Impaired, Double Amputee, Deaf/Blind, Special Rules and Severely Visually Impaired, I think HAEMODIALYSIS may need to be considered further since some people may be able to Dialyse themselves.</p>
ONLINE349	<p>1) I would like to see DLA or the new system to be integrated with the new personalised budgets offered by Adult Care services. This is surely not joined up thinking. The benefit should look at what a person needs to buy.</p> <p>I also think that people should account for how they use this extra funding. There is more and more availability of car pools and shared transport, Most severely disabled people do not use their car very much at all - or dare I say let their spouse or adult child use it much of the time. In rare cases I think people might have their own car but generally there could be a booking system and they could be delivered to and from people's homes much as the company Enterprise does this.</p>
ONLINE350	<p>1) disabled people are affected by a general lack of acceptance so attending activity specially planned are very important though usually overpriced some people need dla to help cover the cost of attending and travelling to such activities, aids are also needed</p>

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	<p>incontience aids specially, removing funding could result in disabled people being further isolated and destroy confidence and social skills that have taken years to aquire</p>
<p>ONLINE351</p>	<p>1) This depends greatly on the disability. It seems that there have been some wonderful improvements for people with physical disabilities to access society but very, very few for those with disabilities such as autism. eg someone in a wheelchair can, in theory, go to London and visit the museums. But if you are unable to function in a crowded space due to autism then London will never be possible for you and I don't really see how any government can change this. I'm not sure how you would be able to determine this sort of impairment in an interview or issues such as being so drained from social contact that a child has to come home and go into a dark room by themselves for several hours because of the overload from having to be around other people on an outing.</p> <p>3) Unable to use any childcare in a normal way. Always having to pay for activities at higher rate for a child because they can't go into group sessions. eg learning to swim can't just be group lessons at the local pool. I have to drive 45 minutes to the other side of the city and pay for private lessons with a 1:1 specialist teacher.</p> <p>5) My experience is with autism so I can only comment on that. In all the years I have looked after my child with autism and attended activities for autistic children I have NEVER seen one child who did not need significant support. It seem absurd to have to interview a child with a diagnosis of autistic spectrum disorder when they have already had multiple assessments/appointments with consultant paediatricians to get the diagnosis in the first place and, according to research, autism is a life-long condition so there is no 'getting better'. I feel that children with a diagnosis of autistic spectrum disorder should automatically qualify for DLA and think you would be hard-pressed to find one person who would disagree. Also due to the way that the disability affects these individuals, an interview with an unfamiliar person in an unfamiliar building would be deeply distressing and many families would then have to cope with extremely difficult behaviour from their child for several weeks after the interview as this is how many autistic children respond to any change.</p> <p>6) Being able to communicate your needs so that someone can help you. Without this, you cannot do anything.</p> <p>8) Yes, disabled people should be assessed according to any aids and adaptations that the NHS would cover unless the aid would be detrimental to their health.</p> <p>9) My child has autism and too many of the questions on the claim form assumes the person applying has a physical disability. All of the parents I know who have an autistic child have complained about the same issue. It is as though only a small fraction of the DLA form is appropriate for autistic children yet their disability is severe.</p> <p>10) This is a really hard question! If the person has a very clear diagnosis of a life-long disability which was made by a consultant it seems absurd that they need to then 'prove' to the DWP that they really are disabled. If people do not have any formal diagnosis of a life-long condition they should have to an assessment by a doctor.</p> <p>11) My child is autistic and would find this terrifying! This is the change that concerns me most. I feel very strongly that if someone has an autistic spectrum disorder they should not have to do what any expert on autism will tell you they find very distressing: meet a new person and answer questions. My son cannot even cope answering questions at our local GP who he is familiar with. I feel very strongly that if someone has a diagnosis of a social disorder they should not be subjected to this.</p> <p>12) We already do this. My son only got awarded for 4 years then we had to go through the entire process again. This was a ridiculous waste of time as he has a life-long disability and there are no aids/adaptations for autism! I would love to think that his condition will improve but unfortunately research does not suggest this for autism.</p> <p>13) Maybe sending a letter out once a year. This could be a form letter sent out to all people who receive DLA where you would either</p>

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	<p>tick a box stating "No, my circumstances have not changed over the passed year" or "Yes, my circumstances have changed" and then leave space to describe the changes. Finally requiring the person (or carer) to sign a statement that their response is honest.</p> <p>14) I hope there is more support available to people with other disabilities than our experience of support with autism. The main support for children with autism in our area is about to be cut! Anybody with a diagnosis of autistic spectrum disorder would already have seen so many health professionals that they would already know what is available.</p> <p>15) It's hard for me to understand this question in terms of autism. There are no aids/adaotations which can improve the condition other than the parent constantly modifying the environment. eg not exposing child to large groups of people, no sudden loud noises, don't go to new places etc.</p> <p>16) This seems very unfair if you have a condition for which there are no aids/adaptations. No hope of improvement.</p> <p>17) Research shows that it is a lot more expensive for parents of a disabled child to raise their child than a non-disabled child. Where are normal families expected to find the money to continue raising their disabled child's extra needs? I already know of several families in my area who are on the brink of placing their autistic child into permanent care because they cannot cope. The cost of this care (outside school) is over £100,000 per year. How can forcing families into this situation by scrapping DLA for children possibly be cost effective? Not to mention the social obligation. I cannot comprehend how a school meets all the needs of an autistic child? They are only in school for 6 hours/day. There are 24 hours in a day. Who do you think looks after them for the 18 hours they are not in school? Not to mention all weekend and all school holidays!</p>
ONLINE352	<p>1) Whilst access is improving slowly, it is wrong to assume that human geography issues and discrimination have gone away. It is unfortunate that legislation allows too many loopholes and that any enforcement requires a disabled person to sue without any backing from the state</p> <p>2) Yes, not means testing it.</p> <p>3) Travel outside of one's home, be it a mobility vehicle, scooter, taxi to from accessible public transport or a combination. Extra domestic washing, cleaning and heating. Extra travel to clinicians for extra appointments</p> <p>4) Don't see why this would make it easier. It's mainly computer driven. Providing people have capacity it is clear what has been awarded and why. One would still end up with a number of different permutations albeit less. This must lead to lower granularity and subtlety of assessment.</p> <p>5) If the vast majority of people with a given long term condition end up receiving the allowance, it does not seem cost effective to check all just in case a very small minority may end up with a bit less or a bit more.</p> <p>6) A multi disciplinary assessment with appropriate assessors to the type of impairment. But all that sounds more costly than what exists now. To be able to do the following if one wants to: Get up, get washed, eat food one's chosen and cooked, go to work, socialize, get to bed. Be safe. Be healthy. Don't endanger others.</p> <p>7) Firstly, accept that some conditions do fluctuate dramatically. Second make sure the extent of the individual's fluctuation is understood along with its impact. Third understand where the person is in the range of fluctuation when they are assessed. Ensure that an appropriately knowledgeable condition specific assessor undertakes the assessment with multi disciplinary support.</p> <p>8) It depends. If the person has / is purchasing the aids and adaptions with the allowance they should not be included. If the aids and adaptions are provided free by the state so much so that the effect is that they are effectively no longer disabled they should be considered on a case by case basis. 'Might' is too weak. If the person might be eligible the assessment should not concluded until it is determined whether or not they have the aid or adaption.</p> <p>9) The form IS easy to fill in for those with capacity BUT long and tedious as well as depressing as it forces self-reflection especially for those who have become disabled as opposed to always being as they are now.</p>

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	<p>The form should sign-post people to organizations that can assist people filling the form in accurately and truthfully.</p> <p>10) All impacted clinicians and social workers. Ask claimants to describe what they would like to do on a day to day basis and what's stopping them i.e. in line with Personal Budget thinking from up to date social work practice. Remembering that existing claimants may well be using existing allowance to fund what they do now.</p> <p>11) Should weed out fraudsters but at an increased cost and potential stopping more timid claimants. As long as the claimant could choose the location it should be OK</p> <p>12) Judgment of condition specific knowledgeable assessor and there should be different types. EG it may be that something suddenly is curable or medical knowledge changes. The system should have the ability to flag up such cases</p> <p>13) All current letters state that changes should be reported. If this is not working the claimants' completed application should be returned to them every so often to ask them to check in detail whether anything had changed and confirm. But it must depend on whether you think people are deliberately or accidentally not keeping you up to date and the costs or changing / enforcing adherence.</p> <p>?) That it's not means tested and therefore no disincentive to work or volunteer. What agencies can help with completing the form. Yes as part of the process.</p> <p>?) Yes but not so much as to increase processing times by adding more 'bottlenecks' or by stopping timid claimants from applying.</p> <p>?) Assuming the state won't pay; by saving up DLA or using savings and then repaying themselves by DLA or using savings in the knowledge that money from DLA will cushion them from expenses that their savings could have done if they had not have spent them on the aid or adaption. Yes there should be an option for a one off cost payment.</p> <p>?) Very important and useful. Many forms ask, "Do you get DLA and at what level?" saving many pages of form filling. Passporting from DLA is poor and usually at the other end i.e. it is the other service that asks the question to speed its processing up. Yes include literature with the annual letter.</p> <p>?) They get older. Needs are likely to change more quickly than adults. They are less likely yo be able to speak for themselves.</p> <p>?) Extra processing time, greater delays, increased repetitive. form filling.</p> <p>?) DLA, AA, Social Workers, Car Tax, Tolls, Congestion Charges, Disabled Travel Passes, Carers Allowance, Direct Payments, Personal Budgets, Individual Budgets. Use the Single Point Of Assessment System.</p> <p>?) None</p> <p>?) It has been badly publicized - only by word of mouth and third sector disability groups. Should have been told to all claimants with the Christmas Payment letter.</p>
ONLINE353	<p>1) Disabled people are affected by physical and mental difficulties, and the resources they available to them that enable them to manage these difficulties can affect their quality of life. I am agoraphobic and cannot leave the house by myself. I have no friends so my participation in society is severely limited. Due to limited mental health resources in my area, I have received no help dealing with my agoraphobia even though I have been 'on the list' to get a cpn for over a year. Disabled people are also often limited by the attitudes of other people.</p>
ONLINE354	<p>1) I am of the view that disability benefits in general are considered to be associated with being housebound, bedbound and workless. All three states are in themselves a significant barrier to participation in community life locally, regionally and nationally. It is true that the numbers of us in receipt of higher rate DLA support appear to be few and certainly spread far. Again personally, my DLA is used already as a means of achieving independence and of staying employed full time and contributing on a voluntary basis to a range of commnity organisations locally, regionally and nationally. Loss of DLA would curtail my participation. However, I struggle with the mindset of those both disabled and non disabled who do not place disabled people at the centre of community participatinf and contributing to community life</p> <p>2) The mobility component is a crucial element of the benefit. Living in a rural community (to which disabled people should feel entitled to do) is hugely expensive and problematic</p>

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	<p>form of residence. The cost of public transport including taxi's to and from a rail station would amount to 26k over a period of 3 years. As a motorbility car user this costs is not even in thatb league in fact is about a third over the same period of time. It affords enormous flexibility including management of medical needs en route. Socially it opens up the world to perticipation in work, shopping, visiting attractions etc etc.</p> <p>I am less confident as to the care element which is a strange part of active disabled life. Again it assumes personal care needs in its model and looks less to the outside world of participation and engagement. I have in fact used my care component to pay for a number of expensive aids and adaptations in the home including heating oil necessary to regulate my body temperature. I have made the choice and made mistakes and incurred enormous debts in doing so but I have the semblance of a warm and comfortmatable home.</p> <p>3) Flexible travel has to be a significant part of disability life particularly where more than one person is involved. Groups of disabled people socially and in employment need to travel independently and cannot rely on public transport to do so. In any event transport in rural communities does not touch all villages and hamlets.</p> <p>The cost of participation plays a major role in equality. As a social work manager, I do not go on holidays or trips unlike my colleagues as to join in or to go on holiday is too expensive in itself but requires a carer to travel with the disbled person in lots of cases or assistance with organising and ensuring access. I have travelled to locations after I have made lots of enquiries received assurances only to learn there is no access in reality because there is a barrier the provider has not considered.</p> <p>My wheelchair need to be looked after, insured, maintained, reprovisioned, updated and changed. It takes a huge amount of wear and tear and I cannot afford to always undertake those changes certainly not replace a terminally injured model because the costs are so high.</p> <p>5) There is potential for the first option where it is known thatb support is needed for an identifiable periodn of time and therefore with a review period. However there also needs to be a combination of the medical approach, definition and understanding of a condition in partnership with understandingb and assessment of needs. Speaking on behalf of those with a neurological condition such as Multiple Sclerosis there are inevitable difficulties as a consequence of the fluctuating or varying nature of the condition whilst equally there are those who have moved into the progressive part of the condition and whose health, wellbeing and disability will continue to decline. Finally there are those with primary progressive MS who are profoundly impacted from day one.</p> <p>Again from a personal perspective, I was diagnosed with relapsing remitting MS twenty years ago but did not claim for DLA until such a time whereby I was profoundly impacted in my work, social life and home life about twelve years later when secondary progressive MS and a ththyroid condition and now arthritis have presented significant diffiiculties and problems in everyday life. This has presented dilemmas to be resolved and DLA has enabled this to happen and for me to maintain as far as possible my employment status. I am committed to working until no longer possible (and that is some way down the line from my perspective)this in itself reduces levels of isolations, keeps me linked into community, activity and participation but none of that is possible to resolve without state help through DLA and through Access 2 Work.</p> <p>7) The gathering of a wider range of evidence based on observations and analysis over a period of time would be of assistance. However, it is important to listen to, acknowledge that information and not for the assessor to dismiss that information. So the GP must have a role as to any specialists such as neurologists, psychologists, urologists etc etc who together provide the most difinitive picture of a persons condition. Equally where a social worker has been involved and an occupational therapist that information must be included. Where all that info is available, it is hard to see how that overall assessment can or should be bettered or challenged by a DWP medical assessor. We pay for a health service, for a range of medical specialists to provide oversight and management of the condition why would we then not trust their combined views?</p> <p>8) The assessment needs to be flexible and look at what has been achieved in terms of aids and adaptations but must not assume that those aids and adaptations are suitable or indeed capable of continuing on forever.</p> <p>I am not sure where any adaptation can be assumed to be easily attainable as it may have required considerable planning, trialling or procurement. most importantly imagination and involvement with other disabled people as to its suitability!</p> <p>Overall the assessment needsn to focus on need and functioning and can where</p>

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	<p>appropriate take into account an aid or adaptation. As a wheelchair user, I experience barriers that are physical and barriers arising from public attitudes but not to have the wheelchair diminishes my participation and reduces the size of the world I live in. It is a complex relationship which i would not be comfortable to address with an assessor where its presence impacted on the assumptions and outcomes within the assessment.</p>
<p>ONLINE355</p>	<p>1) In struggling economies it is very hard for organisations to accommodate disabled people who need high levels of support, who are unable to work conventional times/required hours, who may not need lots of time off, unable to do many of the tasks required stated in a job decription, who do not have the resources to undertake staff training or resources that allow staff to be interrupted. Many disabled people do not have recognised qualifications and are unable to attain them.</p> <p>Transport poses significant difficulties for people who are unable to pass a driving test or are unable to use public transport independently. Travel concessions often are only available off peak so for part time employees on a low income this is a significant barrier. Many busses are still inaccessible, disabled assistance often has to be booked when using the trains. Outdoor electric wheelchairs are not available on the NHS unless one is also required inside the home. Scooters and electric wheelchairs are not appropriate for all disabled people with mobility impairments yet there is a very limited range of walking aids on the NHS market which are not always suitable for someone who needs to use it for more than a short time/distance.</p> <p>Attitudes - these still have a long way to go. People are likely to be more understanding or tolerent when they can they move past seeing a physical impairment however, they are less tolerant with more hidden disabilities such as speech, communitication, ability to process information and behaviour that is not understood or deemed acceptable.</p> <p>Low income often means that disabled people still remain hidden. Often there is lack of support to enable disabled people to access mainstream activities and are unable to afford the cost of paying for a companion or enabler.</p> <p>Carer's allowances are too low and this compounds the difficulties of accessing the same opportunities that would help contribute to someone participating and leading independent lives. Carer's become entrenched in their responsibilities that further 'disable'</p> <p>2) No</p> <p>3) It is difficult to imagine how a consisttent personal independence payment is congruent with an individual assessment.</p> <p>Extra cost may arise from being unable to pass a driving test or use public transport without assistance therefore, have to rely on taxis.</p> <p>Increased utility bills as a result of keeping a home warmer, using more water for bathing/washing clothes/bedding etc. from not understanding about price comparisons, energy saving, how/why the need to reduce energy consumption. May spend need to replace clothing more frequently. Need to buy in specialist support or services.</p> <p>Purchasing equipment not provided on the NHS or through DFG or not being able to wait for these processes to complete. Prescription medicines, alternative therapy, transport costs to hospitals etc. Have to purchase convenience foods. Bank charges.</p> <p>4) There seems little point in providing two rates for each component when someone is assessed for a Personal Independent Payment.</p> <p>It would be much better to introduce a personal budget that is based on needs and one that offers a decent standard of living that enables people to participate in society. There may be confusion and increase administration and processing resources.</p> <p>5) Again, it appears pointless advocating for a Personal Independence Payment if there is automatic entitlement based on a diagnosis rather than how it affects and individual.</p> <p>Cerebral Palsy for example, is an umberella to describe a potential underlying medical explanation. Yet no two people are affected the same. This is true of Autism and Down's Syndrome. How a medical condition affects someone and their ability to deal with their situation is so varied. I don't believe there ought to be an automatic right to PIP - needs ought to be identified but then how they are met may come from a variety of sources e.g. health and/or social care. Most importantly, disabled people are taken out of poverty and are given enough money for them to make the most of their life.</p> <p>6) Any PIP should be paid directly to the applicant and only to another party if there is legal agreement. So many disabled people still experience financial abuse so the money paid through DLA does not improve quality of life. There are some disabled people who want to access mainstream activities but cannot achieve this. The G'ment must provide financial support to organisations who are willing to work with specialist organisations to offer</p>

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	<p>support to disabled people who cannot be employed through other routes. Disabled people themselves ought to receive a decent wage so that they are not worse off by working reduced hours. Greater support to organisations who actively encourage and enable great integration. Ask disabled people. Increase efforts to break down discrimination and prejudice, encourage a society to embrace and value diversity so that it becomes unacceptable to stare, make fun, intimidate or bully disabled people. In my experience, disabled people who really find it difficult to access mainstream/purposeful activities can become depressed, self loathing and distressed. They can easily become isolated and their behaviour or feelings can become overwhelming. Social interaction and support networks are important. It is not acceptable for a young disabled person to live the life of an older person because they do not have the skills or means to participate fully in society or even their local community. People need to feel that they are driving their own destiny, they need to feel they have realistic choices, valued and accepted. PIP award ought to include the cost of a social life and holidays.</p> <p>7) Undertake an initial assessment that includes information from experts regarding anticipated future needs. Build in a review date, collect information of actual needs then adjust the PIP accordingly. If the condition will continue to fluctuate set another review date. The actual full cost of undertaking frequent reviews needs to be considered along with resources available. Nothing is worse than hearing that it costs more to 'police' a benefit than the amount paid to the claimant.</p> <p>8) These should only be taken into account if they already have them or could be provided on the NHS, PIP, funded through DFG, are appropriate and required on an ongoing basis. If the aids and adaptations are essential and enable someone to undertake independent activities and participate fully in mainstream activities, including work or leisure, then it is reasonable for them to be included in the assessment. It does not seem reasonable to financially punish someone if they refuse to use aids/adaptations. Adaptions should only be included if they can generally be found in a public buildings/places of work or leisure centres. At home a person may be quite independent because it has aids, adaptations or laid out to increase independence. This is not always the case outside the home so a person's ability inside the home cannot always be replicated outside it.</p> <p>9) How someone completes a PIP claim form should be determined by the applicant and it ought to be available in various formats including voice recording. However, the option of face to face support to complete any claim form ought to be available. This person ought to be independent from the DWP and have specialist experience and disability trained. The claim form should be simple, in plain English with an Easy Read version. A positive PR campaign will be needed to persuade people that the PIP is more than saving money.</p> <p>10) Confirmation of a medical diagnosis with prognosis - GP, Consultant.  A list of people who are or have recently provided support, submitted by the claimant or advocate.  A supporting statement from someone who knows the person very well and can verify information provided, submitted by the claimant or advocate.  A numeracy, literacy test or IQ assessment(if appropriate)submitted by a Work Choice assessor or equivalent.</p> <p>11) Will the healthcare professional be trained to assess needs using the social model of disability? Healthcare professionals are sometimes perceived as experts. People may feel like they are being interviewed and may not want to talk about themselves. Face-to-face meetings have to be informal in the first instance and it is important to foster rapport. The face-to-face discussion has to be done by someone who has experience of communicating with a range of abilities and understands how someone's medical condition may impact on their ability to undertake everyday activities. They would need to understand body language, understand more than just words and able to use a variety of techniques to get the information they need to complete a PIP assessment if it is to be accurate. Asking someone if they can tell the time is a redundant question if the actual ability to tell the time is not recorded and evidenced.</p> <p>12) I thought this had been answered elsewhere. I believe reviews ought to be based on whether the medical condition is organic, whether there have been any significant changes that would have warranted a review and if so what is the time factor? Whether the prognosis indicates that there is likely to be a significant change and in what time frame. For example, someone who was born with an underdeveloped cerebellum, nystagmus and MLD has a condition that is unlikely to change significantly. The need for mobility aids, large print, easy read information is predicted to continue indefinitely. There is little point</p>

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	<p>in reviewing this case on a regular basis. However, someone who has a physical injury that results in temporary disablement may recover in which case it seems reasonable to set a review date determined by the predicted period of recovery. At the first PIP assessment, a decision to determine whether the claim is subject to future review ought to be made. Some disabled people should receive an indefinite PIP award and the decision to request a review ought to be left with the claimant or their advocate.</p> <p>If a review is carried out then it should be a quick review revisiting information given in the first instance. If a slight change has occurred then another review date could be set and the claimant be asked to repeat the first process of the first claim. The cost of the review needs to be considered and only undertaken if it is likely to result in a reduction of payment. The first PIP assessment ought to determine whether the applicant has a responsibility to report any changes or whether this will be done through an automatic review process.</p> <p>13) The first PIP assessment needs to determine who is responsible for reporting changes. There are some disabled people who do not have the capacity to report this information and do not have mental capacity advocates. If the department wants to know whether any changes that have occurred which would have resulted in a reduction of PIP then it has to employ staff who are able to maintain regular contact with claimants. This can be done through email, voice recording, telephone. There are some people who it is not reasonable to prosecute. At the same time, the department would not want too many people making contact to report changes that would not necessarily reduce the PIP award. The claimant ought to be given a clear report of their PIP assessment with clear reasoning of why they have been awarded the PIP, when it is appropriate to report changes as well as what changes need to be reported. This information needs to be in plain English and Easy Read. People should be given a number of different ways to report changes including a face-to-face meeting if this is preferred so that any queries can be dealt with at the time. People do not report changes now because they assume that the DLA will be reduced or withdrawn along with any passport entitlements.</p> <p>14) Holistic needs ought to be part of the benefit claiming process. There is no point asking someone to fill a form in if they have poor literacy skills. There is no point expecting someone to attend an appointment if they are unable to travel independently so need to arrange support. The process needs to explore what someone can do, what they would like to do, what they can access to make things easier for them, then explore who can provide the right support and/or equipment. The PIP should be able to refer to other agencies. The process ought to be about enablement, motivation and personal fulfillment. Providing information and advice may not be enough and therefore, financial support ought to be built into a PIP assessment to ensure the person is able to participate in the assessment.</p> <p>16) Aids and adaptations are funded through the NHS, DFG, charitable organisations and privately funded. However, equipment is not always suitable or available. The PIP ought to include an entitlement to purchase aids/adaptations or provide a quick referral for assessment. The DWP would have to determine whether the cost of paying for the aid/adaptation would improve the claimant's quality of life and/or independent living skills. If for example, a wet room would enable someone to shower independently then this could only be seen as a very positive improvement. There would have to be some sort of agreement with the DFG department who I expect, would normally fund this type of work. If a PIP assessment reported that a person's quality of life would be improved by using an outdoors electric wheelchair, a passport referral could be made to the wheelchair department for assessment. The PIP would purchase the electric wheelchair as this would not have been provided on the NHS on the grounds that the claimant did not use an electric wheelchair in the house. This could be a one off payment (within a given time frame) that does not prevent the claimant from a mobility award.</p> <p>17) The difference in the child's needs compared to the needs of their peers. For example, a baby or toddler requiring oxygen should not have to wait to be 3 years old to be eligible for a Blue Badge, Warm Grant or PIP (an example). A baby or toddler's parents should not have to wait for years to be eligible to apply for a motability car. The parent's /unpaid carer's needs should also be taken into account.</p> <p>?) Offer a one time holistic assessment based on the universal credit eligibility topped up by a Passport that offers different levels of additional support. e.g. from free prescriptions etc. to the ability to purchase specialist aids/equipment not available on the NHS. Passports could also ensure that people have a greater choice of what can be bought with</p>

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	<p>money from the community care grant.</p> <p>?) Currently benefit forms are confusing and time consuming. There are too many forms to complete and too little support available. Claiming benefits relies on people have the right information and using the right words. For some disabled people this forces them to rely on other people and therefore, open to abuse. Effective passports could save time and money on administration and processing application forms if a holistic entitlement is completed. Assessments would need to be undertaken by specialist people though who are not gatekeepers.</p> <p>?) In real terms any benefit or financial support package could be amalgamated if holistic assessments were realistic and offered people a better than basic standard of living. Only basic information ought to be shared but if the range of benefits were reduced then there would be far less information to share. I personally would not like to see more than very basic information shared. DH, Social Care and DWP could all work closer together rather than being territorial about what they will/will not provide.</p>
ONLINE356	<ol style="list-style-type: none"> <li>1) limited transport if you are refused dla</li> <li>2) the choice to swap your allowance for a car fully covered insured etc</li> <li>3) you have to pay for extra incontinence items also if you are over 65 you dont qualify for dla but that dosent stop you being disabled extra heating specialised food</li> <li>4) the money will not be enough to aid that person</li> <li>6) being able to get out with whatever help care you need to socialise to feel part of the world</li> <li>7) see the persons local gp not somebody paid to just get them off the system</li> <li>8) all considerations should be taken into account especially what will happen in the future and what the person needs now all aids both used in the present and the future</li> <li>11) if the professional is just out to fill a quota trying to bring the dla bill down and is not concerned about the actual disabilities themselves not outside agencies who get paid for disqualifying persons from dla</li> </ol>
ONLINE357	<ol style="list-style-type: none"> <li>1) The major barriers are isolation and the inability to access society on a daily basis in a simple and meaningful way. This is especially true for people on the Autistic Spectrum as their problems understanding the meaning of communication put them at a disadvantage before they start. Being part of the community should not be being left or thrown into the community, but rather being given the support to access society on a day to day basis. The ability to access work of some sort on a regular basis is critical to the development of relationships with other people, roots and anchors in to the community and the ability to participate and give back to the society that is supporting you is very important.</li> <li>3) Disabled people on the Autistic spectrum face extra cost of support as they need to have a smaller group on regular carers to support them in both daily living and any other disabilities they face in addition to the extreme communication needs that doubly affect all other areas of independent living. For example type 1 diabetes and autism requires the cares to have knowledge of diabetes, hyper and hypoglycaemia, the treatments to provide in acute and chronic situations, the ability to measure blood sugar, prepare and give insulin injections and communicate this through non verbal means as well as be aware of food intake and sugar values and communicate this from one carer to another in addition to the day to day caring.</li> <li>4) For profound disabilities like Autism splitting components into mobility and daily living also tends to push the questioning around the physical causes of mobility rather than the in the case of Autism the mind controlling physical mobility, but not as a mental illness, but as a state much like a person who has limited mobility because they have lost a limb.</li> <li>5) I think that for profound disabilities where there is no prognosis of recovery then automatic entitlement should be used. This become especially apparent for people who cannot talk or communicate due to their disability.</li> </ol>
ONLINE358	<ol style="list-style-type: none"> <li>1) I believe the public's attitude towards disability is the greatest problem or barrier. Just because a person uses a wheelchair doesn't mean they have a low IQ or are unable to undertake work. Many employers (particularly small companies) do not make 'reasonable adjustments' to allow disabled people to participate in their company. Prejudice exists. Society has gone a long way to accept disabilities but it needs to go further. The government hinting all disabled people are 'scroungers' e.g. by ensuring maximum publicity for anyone who wrongly claims DLA receives (and by not publicising the major fraud scandals?) builds up societies perception of 'disabled scroungers'.</li> <li>2) Ensuring it is not means tested or taxable shows that the government acknowledge</li> </ol>

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	<p>disabled people have additional costs just to be able to live. I would prefer to see the three levels of care stay. It is good to read there will be a right of appeal but the system needs to be simplified as at present appeals can take upwards of a year to be heard at tribunal.</p> <p>3) Main costs –Each person is different but for me transport and personal support/help/assistance are my highest additional costs. Various living aids, upkeep of wheelchair and various medical needs (not covered by prepayment prescription), additional heating and lighting, additional phone calls come next.</p> <p>4) The disadvantages</p> <ol style="list-style-type: none"> <li>1. Claimants who need help some time of the day eg taking tablets on a morning/help dressing or making a meal will, I suspect, lose their allowance and will be disadvantaged because they will have to pay someone to help from any other income they receive. This means financial hardship to many who need some help.</li> <li>2. I understand medicals are to be harsher and conducted by ATOS who do not have a particularly good reputation. I foresee that many in higher rates will be moved unjustly to a lower rate because of the inadequacies of the system. This will cause significant hardship. Medical professionals need to be fully involved and notice taken of GPs, OTs and physios reports. This would reduce need for an external 'medical' assessment by ATOS or similar.</li> <li>5) It depends on how a condition affects a person. This is where reports from the claimants GP etc should be used as they understand their patient and needs far better than a questionnaire response or external medical professional.</li> <li>6) Seek the advice of the medical personnel closely involved with the claimant. Planning and making a journey does not take into account the difficulty in actually undertaking a journey! I could plan a journey from say the North East to London. I know I have to arrange taxis and help to get to a station, arrange for a carer to be with me on the journey, assisted travel to ensure ramps provided and seat access, taxis and help in London. The impact of this planning plus the journey itself will leave me bedridden but yet you are implying because I could plan and make the journey I would be disadvantaged. Perhaps you need to actually shadow a number of disabled people and see the difficulties they encounter in 'just living' before you ask such glib statements/questions re prioritising those least able to live full and active lives. Being able to communicate needs is one thing but the response is a different kettle of fish. Society really needs educating that not all on DLA are scroungers before any alteration to benefits. It is fine to say you are collaborating with various groups but that doesn't mean you are listening to a word they are saying. Really sorry but I just don't believe a word this government says - it is not supporting the 'Big Society' by making life more difficult for disabled people.</li> <li>7) You MUST take into account and believe what GPs, medical professionals and support group say. The application form should not have a tick box to ask if the condition is fluctuating or not. All conditions/patients have some degree of fluctuation.</li> <li>8) The fact that a person needs aids and adaptations means they are disadvantaged. I believe all adaptations should be ignored. A person may not be able to walk but needs a wheelchair - if using it meant no discomfort and an ability to carry on day to day living similar to a none wheelchair user then I might be persuaded but have you tried popping out to the shops in a wheelchair ... it is a military operation. Taxis can't just be called they need prebooking and only at a time which doesn't conflict with hospital contracts, buses aren't all wheelchair friendly some refuse to help with access, many won't take electric wheelchairs. Shopping centres are getting better but many shops don't have lower counters. I could go on. So I believe aids/adaptations should be ignored. It would be far too time consuming to create a list of what helps and what doesn't. On a personal level the two most useful aids are my electric wheelchair and my night splints - the latter immobilise both hands so I need help during the night.</li> <li>9) No idea how it could be made easier but greater assistance could be given in the form of guidance notes. As I've repeated society needs to be educated so adverts, media coverage plus website.</li> <li>10) Best placed person is medical professional working with claimant. I have grave reservations relating to the 'IHP' based on personal and anecdotal evidence. To use an 'IHP' for an in depth assessment not only suggests a deep distrust for medical professionals working with the claimant but an extremely stressful and unnecessary intrusion into personal difficulties and details for the claimant. Can I ask what % of DLA claims are fraudulent, how does that compare with other benefits? How much money is overpaid through mis calculation not fraud?</li> <li>11) Won't bring any benefits as far as I can see. Inappropriate F2F meetings if claimant too</li> </ol>

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	<p>ill to attend. A recent article on Look North related to a lady with ME who had to spend 22 hours in bed each day. It would be inappropriate to ask such to attend a meeting. I believe many other claimants would make the effort to attend and be bedridden etc as a consequence. The IHP would probably be unaware of or ignore the consequence and would wrongly assess the claimant. I believe if an important part of the system is F2F meetings then the system is wrong. The number of comments on the internet and apparently mounting numbers of appeals to tribunals would seem to indicate that the IHPs are wrongly assessing/ recording evidence.</p> <p>12) I do not believe in reviews but stronger penalties for not notifying of a change in improvement. No penalty re deterioration in condition.</p> <p>The paragraph leading to this question and others suggests the government has already decided on their action and this consultation is just paying lip service to it with no intention of taking views into account but to say x number of people took part in the consultation.</p> <p>13) If it is clearly explained at the outset with penalties for not informing of changes (improvement) fixed penalties should apply.</p> <p>14) At present the CAB helps a lot of people but as funding is reduced for them then some advice is needed. Maybe DWP advice drop in centres, phone and email assistance. The system for Access 2 Work has an eligibility process by phone then someone returns a call to you to discuss personal circumstances. Something like that may be useful.</p> <p>15) Such claimants are probably put off claiming because of the propaganda alluded to earlier convincing the public that DLA claimants are scroungers. The public need to be educated emphasising there is a small minority who abuse (and will continue to abuse) any benefit system. Like the adverts for working tax credit the public need to be aware of the benefits available.</p> <p>Avoid patronising language in adverts!</p> <p>16) I can only speak of personal circumstances - the occupational therapist (hospital and local authority), wheelchair services and physiotherapist arranged most of my aids. I paid for some aids plus electric wheelchair to give me some independence (per wheelchair services I needed one but as I can walk a couple of steps with walking sticks not entitled to one under PCT / hospital guidelines), will also have to pay for ramps and stair lift. PIP is supposed to be designed to meet additional day to day living costs. One offs should be separate non means tested grant.</p> <p>17) I believe assessments undertaken by schools etc should be taken into account. If a child is awarded support during the day the person giving the support or cost of support should be used in school. School's have limited resources to meet needs so I think it is fair for any support allowance to be transferred to the school (during term time). The common assessment framework should be used as it includes input from school, social services etc.</p>
ONLINE359	<p>8) Certainly the use of aids should be taken into consideration, but without forgetting that aids are not cures. Thinking of my son, who is profoundly deaf and uses cochlear implants, we should remember that an aid is only that, and needs to be maintained and used correctly (which can be labour intensive). Also, aids and adaptations can be subject to wear and tear, and can malfunction (leading to lengthy hospital trips, or expense, and time without the aid) and the assessment should always consider (i) the likelihood of the disabled person being without the aid and (ii) the impact of not having the aid when needed.</p>
ONLINE360	<p>1. These are many and varied depending upon the disability. Someone with a physical or sensory disability, who can think for themselves will face different problems to those with severe mental impairment. Problems include acceptance, ability to earn a living, ability to care for themselves and the ability to organise their lives.</p> <p>2. Yes, People with a severe learning disability, which is a lifelong disability should not need reassessment once initially assessed.</p> <p>3. Care and transport costs plus funds to access daycare and social activities.</p> <p>4. Not necessarily. This will depend on the criteria for each and also their flexibility Disparity between similar disabilities and also the interpretation of each of the published criteria</p> <p>5. All claims should be assessed initially, but then it will be obvious if improvement or recovery are a possibility. No claim should be above assessment.</p> <p>6. Priority should be given to people dependant on elderly family carers first followed by other family carers</p> <p>Activities most essential are safety, heating, food, getting around, meaningful days and</p>

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	<p>dependance on others</p> <p>7. All conditions vary from day to day so unless you do a daily assessmnet which is ridiculous and out of the question then a worst case senario must be envisaged. The annual assessment proposed should pick up and continuing improvements.</p> <p>8. All aids and adaptations should be taken into consideration and all included together with any outside assistance necessary to make them effective. i.e.wheelchairs.</p> <p>9. Make the initial form simpler and easier to fill in. Tabulate the qualifying criteria and list those likely to qualify</p> <p>10. Evidence from claimant and medical certification from G.P.'s and other Healthcare professionals.Carers, Social Services</p> <p>11. The benefit will be if the healthcare professional really knows the claiment and has been involved with any treatment.Could be confrontational. This can also lead to pressure being placed on the professional by the claiment and/or family members. The professional may also sympathise with the claimant which may affect their objectivity. A standard must be enforced if appeals are to be minimised. End of Life or chronic illness situations spring to mind and also if the situation is likely to be confrontational.</p> <p>12. The type and condition of the diability should determine the evidence and frequency of reviews.There is aslo a cost implication in setting the reviews too frequently. A judgement is required on the likelyhood of improvement. This should determine the frequency. Some conditions in the Learning disability field are never going to improve but may deteriorate during life so there should be different types of review depending on impairment and condition.</p> <p>13. Annual reminders with ENFORCED sanctions if not complied with. More frequent assessments for people not complying.</p> <p>14. Qualification criteria, timescales for acceptance or rejection, what interviews and or independent evidence will be required. Who will be doing the assessment. As much information as practical would be helpful in the claiming process.</p> <p>15. Advice should be available in Benefit Agency offices and at local council hubs. This should include the major details of qualification The key feature should preclude the use of Jargon,and gobbledy gook. Keep it simple.</p> <p>16. I personally don't know how they are funded. My guess is loaned through Social Services.It would be useful if there was a one off cost but who would then own the aid and/or adaptation? would not a loan system be better so that portable adaptation and aids could be recycled?</p> <p>17. Their resilience and ability to overcome adversity. Their age, circumstances and resourcefulness are also important.</p>
ONLINE361	<p>1. A poor attitude towards disabled people is the main barrier Extra costs for basics- pre-prepared food, extra heating, lighting, travel, additional laundry for example. In order the access food etc. is costlier as it involves extra transport, delivery or internet costs to access. For those on both those working and on low income this can be too costly. Often disabled people rely on family support with no remmuneration. The sheer effort involved in performing the basics is not taken into account in the workplace etc., and this can mean that disable people feel isolated and withdrawn from society.</p> <p>5. Deeming conditions are essential and cut out the need for unnecessary paperwork on those who are ill enough to struggle with daily life. This unduly increases administration on an already strched system. I personally think more stringent rules need placed upon those paid under lesser condition that have liklihood of improvement with help eg anxiety/depression and those conditions whereby drink/drugs have featured in causing health problems etc. these conditions merit high rates of benefit but there is no stipulation that any form of support work, counselling or rehab programme need be entered into. I would suggest that without all treatment avenues having been sought and exhausted then benefit for an indefinite period should not be awarded. Claims should always be based on need and circumstance but it is fair that needs of a certain level be expected in certain conditions and this free admin time to focus on more variable claims.</p> <p>6. Physical mobility (for basic tasks and in order to access any place).</p>

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	<p>Ability to perform basic care such as the physical at of eating and drinking, washing and dressing.</p> <p>12. Periodic enquiry was a hopeless system and often DBC's reprioritised those working in PE to other posts when work demand was high.</p> <p>Some conditions do not improve only worsens so should not be subject to repeated scrutiny. Conditions that still have hope of treatment and for that consultant input will show if it's been exhausted. If not then review should be sought with ATOS guidance on frequency. Especially conditions such as MH issues, Rheumatoid arthritis, non-terminal cancer, Epilepsy, Diabetes etc. should be subject to review and again only indefinite once all treatment paths have been exhausted.</p> <p>Conditions like osteo arthritis, chronic heart failure, chronic lung conditions like emphysema etc. should not be subject to review, again once all treatment and possible surgery options have been explored. Renewal of these conditions again waste dept time when there are many other disabilities which merit checking.</p> <p>I think once a claimant with a condition that has been established that say merits say high rate mob and low rate care and the condition has no liklihood of improvemnt then the rate should be set and only middle or high rate should ever be reviewed after that if need deteriorate. Decision Makers often look at all the components under review when a claimant has multiple conditons and some which should will not improve. Why look at components that will never change. Focus is required.</p>
ONLINE362	<p>1) Well one obvious one is money. If someone is rich enough they could employ a driver and an adapted car and have no problems getting around but I don't expect that from benefits. Giving a friend money to come round and help at home - both the fare here - and something for their time makes such a difference.</p> <p>Only a proportion of buses are accessible to those with mobility problems. The numbers of tube stations with lifts is scandalous. Entry to pubs and restaurants is much improved but you do need to know where to go. Using a toilet costs the price of a cup of coffee now as most public toilets have closed down.</p> <p>The lack of waiting rooms on most staions make it painful to travel on trains for anyone with arthritis in winter.</p> <p>Stigma and the perception of incompetance by others is significant in just inhibiting what people allow one to do. Changing employers attitudes would probably make a bigger difference than providing interview and communication skills to disabled people.</p> <p>2) The freedom to spend the money in the way that best suits us. This actually provides individualised care which will always be a pipe dream for the NHS and local authority. Do not have it restricted to what a social worker things is a good idea or a choice from a 'menu of care' as the choice will always be limited to less helpful things.</p> <p>3) Getting things done when it is not possible yourself. Getting to places by taxi when public transport is just not feasible or too painful.</p> <p>Cooking can be rewarding and cheaper than a delivered take away but sometimes just not possible. Supermarket deliveries are helpful but expensive unless you buy an awful lot of shopping. Everything takes more time and for those areas where time is money, how much work one takes on, how much gets done, this costs. If i can get to work and help with home life and I can do the job. Working from home is really useful but does require extra heating costs and as many disabled people will work at home it becomes a disability cost - especially with arthritis.</p> <p>Actually changing employers attitudes to disabled workers would probably have a bigger impact than providing us with interview skills or better CVs but that is a different department.</p> <p>4) It will be easier to administer and undertsand - and cheaper for the treasury as you can just stop paying everyone with less severe disabilities.</p> <p>It will be worse in meeting the needs of disabled peole as it will presume their are only 3 stages - completly impaired, severly impaired and perfectly health requiring no support.</p> <p>7) Give more weight to the supporting evidence from a professional that knows how the condition fluctuates rather than the assessors one off 30 minute Q and A.</p> <p>10) A healthcare professional that has known the individual for more than 30 minutes (what the face-to-face assessment is going to be).</p> <p>Many chronic conditions involve regular use of particular services and they are the obvious people to use. Be nice if they could get paid for this assessment, could it be contracted out to nurses in hospitals, social workers that already work for local authorities so the assessment is by a person who knows the individual and not a new one. And you would</p>

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	<p>not have to employ so many people - their department would have to be paid per assessment or it will just get added to job descriptions with no increase in funding for time spent working.</p> <p>10) A healthcare professional that has known the individual for more than 30 minutes (what the face-to-face assessment is going to be). Many chronic conditions involve regular use of particular services and they are the obvious people to use. Be nice if they could get paid for this assessment, could it be contracted out to nurses in hospitals, social workers that already work for local authorities so the assessment is by a person who knows the individual and not a new one. And you would not have to employ so many people - their department would have to be paid per assessment or it will just get added to job descriptions with no increase in funding for time spent working.</p> <p>11) Everyone will still have to explain their disability and how it affects them - even when healthcare professionals have read their notes they still ask this. Doctors are worst generally only ever reading a diagnosis and nothing else. In my experience rare or unusual conditions will be assessed by someone who not only knows nothing about it but often cannot spell it. The value of these would be for the very unusual cases such as severe manifestations of conditions that are often mild and provide a chance to actually show it is not just someone trying to con the system. It will be expensive coming to see everyone and much less meaningful for those with fluctuating conditions. A good day = not entitled, a bad day = higher rate which is daft. Evidence from a professional who has known the individual for a longer time is much more important for these conditions and should be given greater weight.</p> <p>12) It depends on the consistency of the condition and the age of the person. Aging does not just suddenly start at 65 (or 67) it appears over time as you get older. How about a guarantee that if your condition is the same or worse as when you were last reviewed (or applied for DLA if that was previous time) payments will NOT be reduced. Fine if people have got better their disability is less severe but when you up the criteria people will end up more severely disabled than when awarded a benefit but still not eligible for the new one. I get worse but the system claims I have got better.</p> <p>13) Is this serious you are asking people to tell you they should have less money? Is the tax system run in this way? Please tell us when you think you should pay more tax? No it is done annually. And the way the system works if one gets worse there is no point risking a review as it is more likely to reduce benefit than increase it.</p> <p>?) I just accidentally pressed the "chapter X" button rather than the #leave your response button and you have taken away the answers I had put in. It says at the beginning they can be "saved for editing" - this is a bad system that means I either have to submit each answer without editing having done all of them, or lose them with a careless mouse click. And saving one answer is no good when I had written 10.</p> <p>?) You pay for them yourself or wait and hope for a charity to do so. The NHS is efficient at providing some equipment for short-term disabilities. Don't even think about asking the Local Authority who are just obsessed with stair-lifts and unable to comprehend people could want anything else.</p> <p>?) Very, very important. The passport means you do not need to be 'assessed' by every cinema, theatre, train company, etc before being accepted as disabled. A simple way to prove disability is very very helpful and should be offered to those who are disabled but not severe enough for the new benefit. Saving the assessment time of other professionals allows them to do their job and means I can do my job.</p> <p>?) A waste of time and money for everyone - professionals in local government, contracted companies, private sector industry that encourages disabled people's custom, etc. Passporting is not just about benefits it is proof of disability for other areas. The local authority would have to do individual assessments for Blue Badges, the Disabled Person's railcard would become a nightmare to get because there would be no system of proving one's disability. In terms of Income Support (it is a long time since I was unemployed) it saves assessment time but since they always got the amount wrong with me would not improve the speed with which the payments were made. (It may have improved since then).</p>

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ONLINE363	<p>?) a special case should be made for children placed for adoption whose long term needs often only become apparent at the time of placement.            We need to remain positive about the current approach which bases assessment for children on the extra assistance and supervision children need compared to other children of the same age. This includes social, emotional and behavioural aspects of disability that other systems can exclude. I urge you to continue this.</p>
ONLINE364	<p>4) The two rates will only be more appropriate if those levels are of a financial level which accurately reflects the level of need.            The disadvantages could be if people in receipt of the lowest level of the care component are taken off the new equivalent of DLA.</p> <p>5) Yes, some impairments should mean an automatic entitlement. Certain conditions, from permanent paralysis to life long conditions such as Autistic Spectrum Disorders and Downs Syndrome should be exempt from repeated reclaims and should be an automatic entitlement to benefit. These conditions are life long. There is no cure and people with these conditions will have additional needs for their entire life. For example with ASD's, it is well known and accepted that only a tiny minority of people with an ASD diagnosis will be able to find and keep regular employment. With permanent paralysis such as caused through severing of the spinal nerves, the sufferer will never walk again and will always require assistance with every aspect of daily living skills and self care. The nature of Down's syndrome means that the disability is caused by a chromosome abnormality and will never be curable.            Certain conditions can and do improve over time. The above conditions are just three of many which are life long and will require a high level of life long assistance.</p> <p>6) Whilst socialisation can seem to be of a lower priority, without the ability to socialise a person can become isolated. Isolation can lead to depression which can worsen the difficulties faced by a person who is already finding daily living a challenge.            Socialisation is even more important to a disabled person than it would be to a non disabled person. A disabled person can already feel 'on the edge of society looking in'. Without assistance to socialise and interact with others in a meaningful way, the isolation will increase as will resultant mental health issues.</p> <p>8) Any aids or adaptations should not be used to refuse benefit if these aids are making life easier for the person in question.</p> <p>9) Make the claim form more relevant. Currently the claim form is slanted towards physical disabilities. A person with autism for example, finds the currently claim form very difficult to fill in, in a way that accurately reflects the way their autism affects them on a daily basis. Multiple impairments need to be taken into account. A person with several mild to moderate impairments will be as severely disabled as a person with one single severe disability. There is not enough emphasis on multiple impairments which inevitably result in complex needs.</p> <p>11) Again, with people with an ASD, due to the nature of the condition, face to face discussion is likely to be very traumatic to the extent that it may cause a sudden and severe deterioration in the person's ability to cope on a day to day basis.            Despite increased awareness of ASD's, medical practitioners and healthcare professionals often have a dire lack of knowledge on how ASD's can and do affect individuals. In depth training MUST be done before any healthcare professional is involved in the decision making process.</p> <p>12) Certain conditions lead naturally to regular reviews of the award. Strokes for example can initially cause devastating disability but can improve over time considerably. Other disabilities are lifelong and should be treated as such with regard to reviews. A review in a life long condition is unnecessary and will cause unneeded additional stress for a person already struggling to cope day to day.</p> <p>17) The part of the claim form asking of the child has a statement of SEN should be removed. Many disabled children now do not have statements due to the changes in the SEN and statementing system. A child could be very severely disabled, require a great deal of help, but still attend a mainstream school and only be a School Action or School Action+ on the SEN register.</p>
ONLINE365	<p>1) The physical structure of society, Stairs and Chairs! Both moving around and keeping still can be very uncomfortable for physically handicapped people. I would like every MP to function for a week in an NHS wheel chair.            Also:</p>

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	<p>The attitude of some physically handicapped people; €œI can t do that because I am handicapped €œ Is the greatest obstacle to handicapped leading a full life</p> <p>2) No, this proposed reform does not go far enough. The problems and solutions for the physically handicapped are totally different from mentally handicapped people yet in DLA they are lumped together to the detriment of both. Somebody needs to think outside the box.</p> <p>3) I could answer this for myself but it depends on the disability and is specific to the handicap. For me if I get cold my body ceases to function so the capital cost of providing an environment that can be kept warm and then the repeat expense of keeping it warm are my main extra costs.</p> <p>4) Is two enough? Currently there is no easy way of getting capital cost paid for: automatic doors, lifts, double glazing, ramps all help people remain in their own homes. While the current Mobility Component enables a car to be purchased there is no way the care component can be used to improve the living space.</p> <p>5) Ideally every person should be assessed individually however the administrative cost may make the cost of doing this prohibitive. Any automatic entitlements should be set low and people should be entitled to apply for a personal assessment which could raise or lower the automatic entitlement.</p> <p>6) This is specific to the individual, what is a problem for one person may not be a problem for another. For instance, because I live in the middle of a large town all the everyday facilities are easily available to me. People who live out of town will have transport issues that I do not have.</p> <p>7) This is a tough one, continuous assessment is needed but to keep administrative costs as low as possible averages should be used between assessments.</p> <p>8) Of course, if somebody uses a wheelchair they should be assessed in a wheelchair. However all the adaptations possible should be provided if they are cost effective.</p> <p>9) If the claim process was medical based it would start in the Doctors surgery or Hospital and be the function of the Almoner.</p> <p>10) Whenever a handicapped person visits a specialist a letter is written to the GP, it is important that evidence of specialists is included.</p> <p>11) For an articulate, physically handicapped, person like me interviews are no problem but when all or part of the handicap is mental other methods of assessment may be required, which is another good reason for splitting the benefit between the types of handicap.</p> <p>12) Each handicap type can be grouped into a review frequency, however the individual or the Local Authority should be able to apply for a non scheduled review.</p> <p>13) Each Hospital and GP practice should have a person, (Almoner?) who can advise the patients to seek benefits or advise them that their circumstances have changed and they are to be reassessed. The almoner is responsible for calling a reassessment.</p> <p>? ) Copies of their medical records.</p> <p>? ) Each Hospital and GP practice should have a person, (Almoner?) who can advise the patients to seek benefits or advise them that their circumstances have changed and they are to be reassessed.</p> <p>? ) Yes, or the Care Component turned into a loan repayment like the Motability Scheme.</p> <p>? ) The nature of their handicap. Children need specialists. It may be better to continue with a flat PIP for children.</p> <p>? ) The service providers would have to think about the value of their service to the handicapped, do they need it, would they pay for it if it was not free? Disabled people would have to think if they need the service rather than just take it because it is free. If it were optional, like Motorbility I think thinks would be different. The disabled could be asked: €œDo you want £10 a week or a bus pass, free swimming, free membership of day clubs, free meals etc.</p> <p>? ) GPs (the Almoner?) The greatest problem I see is that this proposal is just tinkering at the edges of the problem and will become an expensive exercise in keeping things the same. By applying the same assessment procedures to physical and mental disablement both incapacities will be disadvantaged.</p> <p>Trying to reform DLA at the same time as Incapacity Benefit is very bad timing. Both reforms rely on assessment and so will be using the same scarce health professionals at the same time. It might be wise to stagger the DLA assessments to 2014-2016 so that it does not conflict with IB.</p>

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	<p>Disablement assessment currently ignores the medical record, where as it should start with the medical record. Should be responsible for completing an abridged medical record for use by assessing authorities.</p> <p>?) The equality groups are formed with good intentions but unfortunately get in between the disabled and the community. They are good at publicity and cause more problems than they solve. They should be marginalised.</p> <p>?) The greatest problem I see is that this proposal is just tinkering at the edges of the problem and will become an expensive exercise in keeping things the same. By applying the same assessment procedures to physical and mental disablement both incapacities will be disadvantaged. Trying to reform DLA at the same time as Incapacity Benefit is very bad timing. Both reforms rely on assessment and so will be using the same scarce health professionals at the same time. It might be wise to stagger the DLA assessments to 2014-2016 so that it does not conflict with IB. Disablement assessment currently ignores the medical record, where as it should start with the medical record.</p>
ONLINE366	<p>1) 1.What does participate mean? Very far from an objective word. 2. Care costs and someone to accompany and therefore make possible this participation 3.Lack of ability, flexibility or social skills 4.Employment may not be possible, especially because too little support is available and job market in dire straights</p> <p>2) 1. Appointee system 2. Money paid every four weeks directly into the bank 3. Excellent that it is a passport to other vital benefits 4.Some conditions don't change so any review, if at all, should be at very long intervals for people in this category</p> <p>3) 1. Support 2. Day services which are often expensive 3. Assistive technology 4. Heating bills higher 5. Clothing wear and tear a problem for many disabled 6. Clumsiness = more breakages for some</p> <p>4) 1. Confusing and may lead to professionals always striving to put people on the lowest in each band</p> <p>5) 1. On an individual level there is the possibility of immense delays, especially as DWP staffing is being cut 2 What does "circumstances" mean? Who will be the arbiter. Another subjective word.</p> <p>6) 1. Communication skills 2. Have they any common sense? 3. Safety concerns? 4. Medication 5.Food and feeding 6.Clothing needs 7.Mobility</p> <p>7) 1.Assess nature,frequency and time spans of best and worst needs and behaviour and average this out</p> <p>8) 1. Cannot replace personal care for people with autism who have no common sense or understanding of how the world works</p> <p>9) 1. Make form more simple and less repetitive 2.Give opportunity for carers and family to fill in a section 3.Far better training for social services to help them assist disabled in completing the form 4.Increase CAB capacity;at present HMG is reducing this</p> <p>10) 1.Support plan type evidence of best and worst days and full risk assessments 2.Parents, carers, teachers, GPs therapists, service employees and circle of friends are best placed to give evidence. Please do not UNDERESTIMATE how well parents KNOW their son/daughter. Take them and their evidence seriously. They live or have lived with the applicant- the professions may meet them once or twice</p> <p>11) 1. This has to be someone who understands the particular disability. If they do they might see inside the life of that person and give the correct award. eg autistic peoples anxiety, deceptive "parrot" responses could be a stumbling block for those with only a</p>

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	<p>generic training</p> <p>2.Circumstances when face to face would be inappropriate: Autistic people, Asian women, those who need support (ie not just 1:1 with professional). GPs often know very little about some conditions</p> <p>12) 1.Some conditions such as autism,need less reviewing than physical conditions which are more likely to improve/deteriorate. Autism is a condition for life.</p> <p>2.Reviews need to be as slimline as possible</p> <p>13) 1. GPs, support agencies both should have a routine professional obligation to report any changes</p> <p>?) 1.As much information as is reasonable in a easy to understand format.Often benefit claimants only find out about other things they should be claiming for by chance</p> <p>2.Access to trained advisers (HMG cutting benefit staff!)</p> <p>?) Don't understand the question</p> <p>?) 1.Don't know but suspect many are paying for their own or families are funding them.</p> <p>2. Additional PIP essential if people are to get the aids they need</p> <p>?) Parents are the experts, please listen to them. They want the best for their child, are the vast majority are not attempting to defraud the system. They are in fact terrified of what the future holds for their disabled child</p> <p>?) 1.Useful BUT we found most of what our son was entitled to by chance. Each family should receive a flow chart, on diagnosis making it clear that if a, then b, c d etc follow</p> <p>?) 1. Colder houses (no Warm Frtont)</p> <p>2. Trapped at home - no mobility</p> <p>3. Time spent in extra applications , by carers who should be caring for person</p> <p>4. Fewer services = poorer life</p> <p>5. Some will become menatally ill or die</p> <p>?) 1.One form could be completed and shared. Would have to be more detailed but this wouldn't matter if there was only one to do. It is INCREDIBLY stressful to fill in multiple applications</p> <p>?) 1.Some degree of separate consideration and action for those on the autistic spectrum. This is often a "hidden" but very crippling disability</p> <p>2.High incidence of disability among the Asian community which is often hidden away. Need female Asian staff</p> <p>?) 1.What if carers don't have the internet?</p> <p>2. What if carers can't afford the document?</p> <p>3.Some is still difficult to read</p> <p>4.Little mention of carers and family who often act as advocates for the disabled person</p>
ONLINE367	<p>1) The extra exorbitant costs of buying equipment to aid mobility, electric wheelchairs, beds, air mattresses, specialised gloves etc. Specific terminal/fatal illness, where some days all you can do is stay still. Barriers into accesable housing, long waiting periods, inadequate care provision for truly 24 hour coverage. Bullying attitudes, people who think work is the solution when you can barely breathe. Governments who belligerently push through reform of things that don't need changing. A lack of specialised consultants for muscle disease. Peoples judgement and social barriers, judgement of mental capacity. Their actual condition, not everyone can fully integrate.</p> <p>2) The tiers should stay the same. Mobility cars for those in residential care AND schools should still be provided, because these people will still need to travel in holiday breaks, to hospital appointments, to sporting events, recreation, instead of being stuck at home entirely. Indefinite awards for proven life limiting and life threatening conditions that continually get worse, but allow a phone call every year to see whether the claimant needs have changed if no end conversation. If yes ask if needs have got worse before assuming they have improved.</p> <p>3) Costs for care and 24h care in the home, costs to eat specialised food, blenders, specialised eating accessories, ventilator accessories, medicines, supplements, specialised computers and aids for said computers, internet provision it allows me communication, paying bills, wheelchairs which cost over £5000, heating your body, pain relief from alternative sources to drugs. Medical supplies. Parking at hospitals.</p> <p>4) It could make it harder to administer for those cases which fall between categories if one of the rates is taken off each component. The problems would be the unfairness of taking current needy claimants off their current entitlement with one sweeping movement.</p> <p>5) Where you know someone has a paralysing life threatening condition that will unlikely get better but will get worse with ramped up care and mobility needs say Duchenne</p>

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	<p>Muscular Dystrophy, ALS, car accidents, spinal cord injuries then indefinite should remain with 1 phone call a year to see if things have improved OR Declined. Otherwise you exacerbate the condition.</p> <p>6) Breathing, eating and drinking, cleaning, communicating, safe housing, warmth, bedding, moving around, provision for socialising, comfort, practical wheelchairs fitted to the individual.</p> <p>7) The yearly phonecall I mentioned previously, for rolling changes, person to person if necessary. Consultant appraisal, others with the same condition appraisal, GP appraisal. Experts in the field etc.</p> <p>8) No, aids are only aids NOT cure alls, despite having a wheelchair, you are still disadvantaged, in height, in travel, in social instances, on buses and trains if available, with space, with toileting, with movement, when confronted with lips in pavements and stairs and steps, narrow shops, inadequate housing, to pubs clubs etc, DDA is a guideline no where nearly enough implemented and has not solved access. Leave aids and adaptations out of the equation.</p> <p>9) Shorten claim form leave out questions designed to catch you out, stop repetitive questions. Use simple english, provide talking forms or braille forms or provide a member of staff fluent in deafblind communication. Provide more assistance.</p> <p>10) Gp's, consultants, experts including those who have the same mobility and care issues and conditions, the carers involved, trusting the person concerned. Yearly one time call.</p> <p>11) Unless healthcare professionals are fully versed in the condition and have spent time seeing the first hand effects they won't understand the claimants difficulties. It would be inappropriate if the claimant has any severe mental health issues or is non verbal or lacks basic understanding. They shouldn't be the sole arbiter, a collection of experts including patient groups, carers, the individual and GP should all be in agreement.</p> <p>12) Once a year by phone or by visit. Reviews to all ask have your needs increased or decreased. Evidence from GP, consultant if needed, trust should be developed by using the same reviewer yearly.</p> <p>13) Develop trust by using same reviewer, always stating that lying will lead to lesser monies until nothing, the same review should know if somethings happening inappropriately. Provide a carrot for the truth to be told with a bonus payment. If suspicions are raised at phone call go to their home and verify after one further year.</p> <p>? ) The tiers they may qualify for, stating far more clearly that it's non means tested or work reliant, other benefits they are entitled to, the yearly phone call or visit explained plus carrot for truth telling.</p> <p>? ) No stick to yearly call/visit.</p> <p>? ) Most so called one off payments don't take into account maintenance of aids and adaptations. Charities and lengthy saving of current payments are used now, along with grants or people struggle on without help. Increased payments would help in that respect.</p> <p>? ) Access the likelihood of the condition worsening as some condition will actively get worse. Take into consideration what children need may be different to adult needs. Trust the parent/guardian to know the progressive nature of some diseases/conditions. Teenagers will have different needs to children's.</p> <p>? ) It's a very important provision of dla to get blue badges and independent living. Leave things as they are.</p> <p>? ) It would not negate extra costs and would add more, it wouldn't integrate people but further marginalise disabled individuals. If you need major assistance in the home you will certainly face the same if not more barriers outside of it.</p> <p>? ) Leave it as is, the worst thing is if different departments started assuming things that might not have been properly assessed.</p> <p>? ) I think its unfair to stop at 65, what if you're paralysed at 65 or 66? Disability hate crimes and personal safety should be taken into account. Mental health capacity. As DLA or PIPs are just for extra costs leave the need for work out, working is a personal decision based on needs and abilities and qualification. A non means tested benefit shouldn't even be considered as a 'back to work' scheme, its a supplement, if you can not tolerate a 9-5 job, other money making schemes could be encouraged such as art and writing. If you cannot work you really cannot, we need to help not condemn.</p> <p>? ) Celebrate the disabled, do not judge us all too harshly. Look after the needy, the widow and the fatherless. Judge not lest ye be judged.</p>

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ONLINE368	<p>1) Here are problems we face</p> <ul style="list-style-type: none"> <li>- lack of accessibility to buildings e.g. restaurants, offices</li> <li>- accessibility / ease of use for public transport e.g access to train, tube , buses is very bad . There are few lifts for tubes ; there are no easily accessible trains - we don't want the hassle of having to call a guard etc</li> <li>- improved access to board and sit on aircraft</li> <li>- funds - disabled folk generally have lower incomes</li> <li>- public prejudice. We have had abuse from bus drivers, other road users and in some hospitals</li> </ul> <p>2) It is one of the better benefits and the mobility and care split makes sense. It should be left in tack as much as possible</p> <p>3) Carers: my wife requires 2 carers 4 times a day Extra transport. My wife used to be a driver but now must use cabs . She can not board a bus or train herself. Energy: My wife used to work in an office - she is now at home most days and therefore needs the heating on all the time</p> <p>6) Basic health care: my wife requires help with toileting and hygiene Getting out and remaining intact with the community: If there were no activities to help with this my wife would just be forced to sit at home ever day with no outside stimulus</p> <p>7) I do not think it can be too finely defined. It needs to be broad based.</p> <p>9) Regular Carers opinions should be rated more highly. They tend to be the ones who know the whole issue</p> <p>10) Conditions vary alot over time . The for once of assessors should be limited. Uses the views of regular GPs, therapists, carers, PAs etc</p> <p>11) If the preson has a degree of brain damage the view expressed to the HCP may be wrong . More weight should be given the the regular GP, support workers etc</p> <p>12) Reviews are likely to be very stressful for the disabled person. They should be done 3-5 years</p> <p>? ) The exact criteria on how decions are made As much openness and honesty as possible . We are not all " benefits thieves" ?) yes - I have not been able to fund a bathroom for my wife yet becuse other funding routes are closed. ?) Don't make it too sophisticated . This can be intimidating to clients and bureucatic. Consider certain key criteria e.g, wheelchair user. The consider getting the views of 3 professionals within the person's life e.g carer, GP, physio. This how the ins. co do it.</p>
ONLINE369	<p>1) A great many people with a disability do not really enjoy being stigmatised or having to bare everything to a complete stranger.. The ways that disabilities affect people is again different as each individual has their own response to pain or lack of movement. I have been disabled for a long time, I was receiving mobility benefit when DLA first came out. It took me a full year, with several specialists reports, before my claim was allowed. It makes us all feel like lesser human beings.</p> <p>2) I have been given a fresh diagnosis now which means that there is a very real possibility that I may never walk again. I will be expected to explain this without showing any emotion. I miss going to work and having a social life but, at 65 I don't expect more than to be able to afford to live.</p> <p>3) How will you be able to tell when a person has multiple disabilities, ie: epilepsy, lupus, spondylosis, MS, osteoarthritis, anemia, and osteoporosis?</p> <p>4) There is no reason why having two benefit rates should cause any difficulties, after all DLA has three care rates.</p> <p>5) Benefit is the right of anyone who has problems but money is a key issue at this time. The people who suffer the greatest need are obviously the people who need it most.</p> <p>6) The most obvious activities are shopping and being able to prepare and cook a meal, but being able to do these things is not much of a comfort when a person cannot leave home, shop or do anything else without being supported by another person. Many people value their dignity still and would really like to be more independent but they can not.</p> <p>7) By monitoring them, but not as 'big brother' as people not number of claimants.</p> <p>8) I am unable to walk properly, due to spinal problems. Five years ago I bought a scooter to get round with but the salesman misrepresented the scooters suitability. Most disabled people no longer trust the shops and mobility suppliers because of this type of thing. I ended up donating my scooter, unused, to a charity for use in one place, not able to be transported as it was to heavy to lift. House adeptations are frozen at this time as they do</p>

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	<p>not have enough money to pay for them.</p> <p>9) If the forms were written to individuals, I don't mean personally to each individual, but to remember that the claimant is a person and has feelings.</p>
ONLINE370	<p>1) Lack of money, and lack of community provision, cuts in local services, stigma caused by newspapers and politicians attacks on the disabled. Unecessary changes in benefit systems causing stress, trauma, greater ill health and suicide. Lack of employment, poor public transport, lack of flexibility with businesses.</p> <p>2) the number of people receiving dla, the amount of dla given, the method of assessing claiments, the other benefits you can get if you get dla.</p> <p>3) if someone cannot walk, how can they get around more generally? many places do not have adequate wheelchair access, do the government intend to make universal wheelchair access mandetory.</p> <p>Subjectivity is helpful with conditions such as ME which I suffer from, where my condition changes from day to day, fitting in soley with a tick box system would be extremely unhelpful.</p> <p>I face extra costs for taxis when I suddenly get ill and can't get home, for my boyfriend having to take time off work to look after me, for food, trying to eat a heathy diet and I can't cook all the time because of my illness and healthy ready meals and take aways are very expensive, for clothes because I am also on mental health drugs and my weight fluctuates constantly.</p> <p>4) This does not take into account the variability of peoples lonfg term conditions. At the moment I recieve lower rate mobility for my metal health problems as they often prevent me leaving the house by myself, this helps me with fees to have things delivered to my house rather than go out and purchase them myself and helps pay for my boyfriends transport when he travels with me because I can't go out alone. I do not recieve middle or higher rate componant because I can technically walk. I am concerned that by simplifying the system and having only two levels of benefit per componant people such as myself with mobility issues caused by mental health will loose out completley.</p> <p>5) of course some health claims or conditions should mean automatic entitlement to the benefit. Things like cystic fibrosis or terminal illness or the need to use a wheelchair constantly for life should be awarded automatically.</p> <p>6) 'planning and making a journey, and understanding and communicating with others' are very specious grounds for judging whether someone is disabled or not. A vast majority of disabled people have physical imparements, not learning difficulties or communication difficulties, as a disabled person, this example makes me very worried.</p> <p>So does your presumption to ask us to prioritise which activities are most essential. This will differ widely for diferent people. What makes me most able to live a full and active life is lack of prejudice and money.</p> <p>7) by building questions into the questionnaire that allow people with fluctuation conditions to answer that they do have a disability.</p> <p>By using properly trained people who have knowledge of tose medical conditions to do the assesments.</p> <p>8) No, categorically not. Wheelchair access is not universal, hearing aids can break, so can artificial limbs, levers for getting in and out of the bath make it easier but it can still be a painful process for some. Also define easily available, some of these adaptations cost a lot of money which people on low incomes can't afford or have long waiting lists. If I had paid out of my own money for an adaptation to make my life easier and then was told I am ineligable for dla as a result I would be highly upset. People with disabilities build adaptations into every decision they make about their daily lives. For example my boyfriend and I bought a flat near the shops and train station, it is smaller than something we might have got elsewhere but that is an adaptation we had to make for my illness and disability. We also bought a dishwasher because there is no way I can wash up. Why should we be penalised for this?</p> <p>9) To make the process of applying for this benefit more positive, the easiest thing to do would be to stop stigmatising and scaring the people having to use the system.</p> <p>The curent dla form is extremely difficult to fill in, I needed a professional from a disability charity to help me fill it in. My social worker was not alowed to help. Either simplify the form or make professional support available to everyone who has to fill it in.</p> <p>If you want to improve information about the new benefit, could the government watch the language it uses in public and clamp down on the daily mail scaremongering. There is virtually no fraud on DLA, if you are changing it it is for cost saving reasons only, calling</p>

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	<p>claimants 'scroungers' and 'lazy' and such things is only going to make people wary of what you intend to do with it and upset and stop people applying for it who are perfectly eligible.</p> <p>10) To get my dla, I had to have a letter from my gp, a letter from my boyfriend and keep a diary for 2 weeks detailing my activities. GP's and medical specialists reports are obviously useful, but many have no time to write more than a few words. People whose condition is stable may have minimal contact with a gp. The evidence of the claimant and people who support them on a daily basis has to be considered properly as well.</p> <p>11) A face to face interview with a healthcare professional should not happen if someone has severe mental health problems because it can be extremely distressing. So would be demanding a face to face interview with someone who has just been told they have something terminal. The option of a meeting in the individuals home has got to be available for everyone who applies. At the moment IB assessments are in assessment centres, these often have stairs, involve sitting on a very uncomfortable seat for hours and usually end up making my ME bad and me seriously ill, just for turning up. To be able to have the meeting in your own home would take a lot of stress out of the proceedings for me, and would stop my health taking a massive step backwards every time I have to get assessed.</p> <p>12) changes in our society don't impact on whether someone has a long term disability or not! I don't have an indefinite award anyway as I was not deemed eligible for one as there is a chance my condition might improve over the next few years. However if someone has a permanent condition they should be assessed as infrequently as possible. Legs don't suddenly grow back! Of course the types of review should depend on the needs of the individual and their individual circumstances</p> <p>13) At the moment if I have to report anything to the incapacity benefit people I have to send a written letter. I have often found this very difficult as I am often too tired/muzzy in the head to write and too ill to get to the post office. ( I haven't had to try to report any changes to dla yet) It would be lovely if it was possible to officially report changes over the phone and the internet too.</p> <p>?) At the moment everyone applying for dla needs specialist help filling out the form. Unless the forms get substantially easier to use that will still be the case. It would also greatly help if you let people know by what criteria they are being assessed when applying.</p> <p>?) no absolutely not. This is highly offensive! How does accessing advice and support make a long term health problem go away? If its actually curable you are not eligible for dla in the first place!</p> <p>?) I don't understand this. I fund my adaptations myself. Lots of disabled people do, others get things through charities and the nhs. At the moment I am entitled to use my dla for whatever I wish, including paying for adaptations. If your question is 'should there be one off payments above and beyond someones usual PIP to pay for something big?' then unequivocally yes!</p>
ONLINE371	<p>1) accessibility, understanding of needs, access to effective treatment, reduce costs of gadgets, adaptations, specialist equipment (including specialist footwear) removing costs of carparking at hospitals for those having treatment, removing the prescription charges for people with chronic illnesses</p> <p>2) Yes the fact that at present conditions which fluctuate are recognised eg ms, rheumatoid arthritis</p> <p>3) Requirement of their own transport is essential to having an independent life: particularly for me as a mum of two young children who cannot get about on public transport.</p> <p>4) those who have been at a higher rate may now find their income slashed, leaving them at disadvantage and restricting how much they can afford to spend on their essential needs</p> <p>5) some claims should receive automatic entitlement eg cancer</p> <p>6) having interaction with other like-minded adults, getting out of the house e.g shopping. Being able to take your own children to school or swimming or to the park. Being in a</p>

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	<p>supportive understanding work environment</p> <p>7) take on board recommendations by professionals who are the most involved with the illness/disability eg rheumatologists or cardiologists and occupational therapists</p> <p>8) Aids are expensive and not always easy to adapt to. They are not always provided by health authorities and have to be funded privately out of DLA. Not all situations are appropriate for the use of aids.</p> <p>9) The claim form is daunting and must put people off with learning disabilities or depression for example. It needs to be a bit shorter and more coherent. Please set up an advertising campaign and get the disability groups on board</p> <p>10) Consultant, GP, occupational therapist, physiotherapist</p> <p>11) Mental illness</p> <p>12) Review for non-progressive conditions or conditions with no cure.</p> <p>13) advertising/campaigns</p> <p>14) Yes but there is a likelihood that this will lead to bombardment of information</p> <p>15) No that's just penalising people who aren't confident of going elsewhere for example someone suffering from depression. Please don't bully disabled people into seeking help elsewhere. Support them</p> <p>16) I fund my adaptations, cost of prescriptions and specialist footwear through my DLA. I also use it to pay for a small amount of domestic help as social services are reluctant to give me any. My adaptations eg kitchen knives have to be replaced when they break or wear out. My shoes have to be replaced if my foot deformity alters. A progressive condition will require adaptations to alter with disease activity</p> <p>17) don't know</p> <p>? ) make them more obvious and simplified.</p> <p>? ) people would be marginalised further and need to complete more daunting applications</p>
ONLINE372	<p>1) Some barriers are in perception of disability (obviously) but, although I agree that some level of work / activity is good for someone with a health problem, too much can be detrimental to health and even dangerous. The issue is that this is not a black and white issue and the current system does not have enough flexibility and is not based on an objective medical opinion.</p> <p>2) It needs changing but not just to save money</p> <p>3) Simple day to day experiences - travelling to work, for example. Again, cheapest is not always best. Attendance for hospital appointments etc. Dietary and clothing issues. Healthier food is more expensive. It is possible that some will not have any extra costs dependent on the disability. This is why there has to be a strong discretionary element in the award but it should always be based on proper medical opinion.</p> <p>4) How will this effect linked benefits such as Carers Allowance? It will not matter too much if this question is adequately answered and the reduction to two rates is not just an excuse to save money.</p> <p>5) Some health conditions will mean an automatic entitlement due to the nature of the disability and its effect. However, I am angered by the number of cancer sufferers I have seen who do not get DLA even though their treatment causes as great a degree of suffering and illness as the cancer itself.</p> <p>6) I have worked with disabled people for the last ten years and, two years ago, had a health problem that nearly ended my life. I do not claim DLA as I do not meet the criteria. However, the quality of my life has declined since the illness, even though I have had a partial recovery. I work full time and receive access to work help on travel but I have virtually no social life and every holiday (a few days normally) has to be planned around my medication. My work, even though office based, tires me to the point that weekends are only there to recover from the fatigue of the week. I see myself as partially disabled and have known a lot of people far worse off than myself - even though the illness has other costs (for me around £5 000 in extra travel costs as I was incorrectly diagnosed by my GP over several months) - but my main complaint is around the quality of my life. Most people with a disability crave normality which is difficult to regain. Claiming DLA is a degrading process that emphasises the lack of normality. There has to be more than just existing when you have been ill.</p> <p>7) One of the main faults of the current system is that it is possible for a person who is disabled to have a good day on the assessment and be deemed ineligible and someone else to have a bad day and get the benefit. Also people with mental health issues are seldom aware of this and will often tell an assessor they are fine when this is not the case.</p>

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	<p>Medical opinion, rather than a series of yes &amp; no answers should be used.</p> <p>8) If someone has a white stick does that mean they are no longer blind? This is a fatuous question.</p> <p>9) The claim form forces the person to concentrate on what is "wrong" with them. I believe this benefit should come via an initial recommendation from a GP or Consultant - despite my own experience.</p> <p>10) A Doctor who knows the individual. The current system almost ignores the GP.</p> <p>11) Why do we wish to ignore initial tests and treatments? If a person has been diagnosed with an illness and had had tests to confirm this, why do we need another "healthcare professional" to do a face to face? If there is ambiguity in the original diagnosis, I can see a need for the discussion. However, if someone has a broken leg will that change by seeing another person? Perhaps they will have super powers! A face to face discussion should only be required in cases where there is ambiguity. 12) Some illnesses are life long others treatable and a recovery can be made. A review that happens too often has a detrimental effect on the client especially when the issue is learning difficulties / mental health. This is another foolish question as to have a set criteria is dangerous.</p> <p>13) This question is not about the benefit it is a thinly disguised attempt to talk about punitive measures.</p> <p>14) A child is more likely to need support than an adult with the same illness for the simple reason that they are a child. Is this a serious question?</p> <p>15) Again this can already happen under DLA mobility. Do we need to change? ) Again, the DLA system has worked on this. The main problem, in my opinion, is that too many people who should get the support are either put off by its complexity and questions or are seen as not eligible who are. I have seen people on chemo and radiotherapy struggling on buses to get treatment when they can barely move and it is a disgrace that are treated like this. Too many disabled people are turned down for DLA. I hope PIP improves this but I doubt it.</p> <p>16) If they are losing funding, that has an effect. If we are serious about streamlining a benefit for the benefit of those claiming it, equality groups will be in favour. If it is just a way to save money, they won't be happy? ) If we are aiming for a "Universal Benefit", this is another foolish question. One of the problems with the current system is that there are too many benefits being paid out by too many different agencies. If there is one, the question no longer has relevance? ) The format of specific questions limits a response. It is therefore "closed" and stilted and reduces its relevance while creating a pretence of openness. Anything that helps people with disabilities will get my approval. Cost cutting exercises without checking on need will not? ) There was a system - CAB, ERC's etc. which have been removed by the cuts of this current administration. I am also aware that many specialist Disability support groups are also suffering on funding and, after April 2011 when current funding anticipate a much reduced service. There will be nowhere outside of the benefit system to get help? ) This would be ridiculous and is almost beyond comment.</p>
ONLINE373	<p>1) the main barriers include negative attitudes, low expectations, poor educational opportunities, ongoing prejudice of employers, inaccessible environments of all sorts despite DDA which is still ignored by thousands of public services and private businesses, lack of stamina to compete with non-disabled people despite equal abilities, exorbitant price of necessary aids and adaptations, high rents, unusable public transport, high costs of taxis, inability of many to drive own vehicle, loss of the access to work scheme, inaccessible information and lack of interpreters, lack of hoists in public toilets for disabled people, exhaustion, insanity caused by struggle to get benefits to which you are entitled.</p> <p>2) Disabled people have been shown to benefit from well run and securely funded local Independent Living Centres where they can gain expert and peer support on everything from housing to employment. In my view these are essential for our equality.</p> <p>3) This is hard to answer because there are so many extra costs involved in being different to the 'norm', but includes having to rent expensive modern properties because they are accessible, using taxis to get around, driving lessons, having to get clothes altered, shoes made, contributing to Disabled Facilities Grants and Motability vehicles - a cost which increases with the severity of your impairment, using hotels rather than B&amp;Bs because of access, endless unavoidable parking tickets, ready meals rather than raw food, enormously expensive equipment including powered outdoor wheelchairs and scooters, often bought privately by going into debt, paying people to help with personal care, housework and personal assistance in life's activities including work, medicines even on prescription, interpreters, computer programmes and hardware to help accessibility eg</p>

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	<p>voice recognition software, training to use such technology, paying people instead of DIY, having shopping delivered, paying for someone to come places with you, eg holidays, visits, admission fees etc. The list is very long.</p> <p>4) A mixture of private, state and charity funding including fund-raising themselves. Yes, people should be able to use their allowance to buy aids and adaptations but mostly they cost far too much for this to be relevant. Do some research</p> <p>5) I believe the reality will be that people will be assessed according to local availability of funding and not individual needs at all. I much prefer the equality of the current system The automatic entitlement to other benefits is great. Don't change it.</p> <p>6) The current system already prioritises those in most need. DLA is already difficult to get especially for those with 'hidden' impairments or unclear diagnoses. Even with the help we currently get, life is a struggle for many disabled people. You should not even be considering reducing the amount of money spent on this group of people or the numbers of people entitled, especially as public service cuts are made. Asking which activities are most essential is the wrong question as many of us spend our DLA on essentials such as food, clothes, rent, heating, travel to make up for our reduced earning power and multitudinous extra costs of living</p> <p>7) variable and fluctuating conditions must be assessed at their 'worst' to be safe. Progressive conditions should be reassessed at least every 5 years. ? I think you should NOT withdraw the mobility component of DLA from people living in care homes. Many young disabled people live in care homes for years. The little bit of freedom and independence allowed by the DLA to, for example, get a taxi to a friend's house is immeasurable. Also many families use it to lease a motability car to take their relative out, or bring them home regularly. Please please please don't do it</p> <p>8) What is more important is how they pay for their aids and adaptations. My wheelchair for example costs £17,000 but makes me comfortable and very independent. Once paid for by Access to Work, I now live in dread of the day it breaks down or I need to replace it. The NHS are very limited in their provision forcing many of us into debt. Charities can no longer help as they did, with the end of for example the ILF and Rowntrees family fund. If I need new adaptations to my flat, eg a hoist to get in and out of bed, I will have to pay a contribution, or possibly all of it if I cannot wait the three years these things often take.</p> <p>9) I have received the higher rate of DLA for many years. It is the most useful, least stressful and most flexible piece of support I get. I do not think it needs changing at all other than making it easier and clearer to apply for. For many people it is a preventative measure and taking it away, or reducing it, or making people jump through more hoops to get it will not save money at all because their conditions will worsen through stress or inadequate support. As we head towards a time of unprecedented unemployment levels for the non-disabled, the underlying hope that we are all going to stop 'swinging the lead' and get a job is pure fantasy.</p> <p>10) There is no one other than the disabled person themselves who can assess their own ability. Supporting evidence is very problematic other than from a close relative or friend who knows the person on a day to day basis. No medical personell have this information, not even a good OT or GP. Many will never have visited the person in their own home.</p> <p>12) some conditions may bring a rapid deterioration of ability and increasing need. They may need to be assessed annually BUT this should not be confused with the assessment for direct payments or care services.</p>
ONLINE374	<p>1) LOCAL SCHEMES HAVE BEEN SCRAPPED THAT USED TO HELP PEOPLE WITH DISABILITIES WORK AND FEEL VALUED-BRING THESE BACK 5) SHOULD BE BASED ON AN INDIVIDUALS REQUIREMENTS.</p>
ONLINE375	<p>1) Disabled people need the independence to purchase their care package in what ever way allows them to organise their personal every day /night care also to enable them to intergrate with their able bodied peers with out the need to have to ask their friends they make to ask for help with any personal needs which arise while enjoying social enjoyment therefore not causing any uncalled for embarishment. These are some of the areas which can prevent disabled people participating in society and leading an independant, full and active life. The need for overnight care when there is a risk to being on their own at night. The need for help with personal hygiene, and the preparation of food, and the keeping their home in order to their standers and wishes that enchances their independant lifestyle, as would their peers.</p> <p>2) When in my post as a Disability Development Officer and after a Parent Support and</p>

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	<p>Development Officer, the need for a shake up of this, and other benefits to look at who, is getting some of these benefits who really should have been reviewed a long time ago was very apparent.</p> <p>3) The most concern and is ongoing is the ongoing rising cost of purchasing care and finding the extra monies needed to be in a position to increase the carers wages because if lost it is very difficult to replace people who are such an important part of your life and this a very real concern.</p> <p>4) I think having two levels will make it easier when assessing the need for different levels of care required, and will hopefully sort out some of the claimants who are questionable in their claims, given the opportunity to have reviews more frequently as needed, maybe in conjunction with Social Services which would give an overall view of the child/adult.</p> <p>5) No I think the DLA for anyone who does not qualify for anything other than the higher limit then should be recalled to check on their ability/improvement?</p> <p>6) Most adults who have been disabled from birth and if by the age of 10yrs have shown little or no improvement will more than likely remain with in reason about the same. Others who acquire a disability then will need checks more frequently to monitor progress.</p> <p>7) Maybe you need to have an independent report from someone who knows the individual in a different setting and can then give a more accurate maybe if there is any doubt in the assessment. Also see my response to the above.</p> <p>8) Yes no one would want to have use aids if they don't need them, yes they can obtain them I suppose maybe all the more need for an independent response even if it means employing someone to observe the person if there is some doubt as to the need for aids?</p> <p>9) Maybe one way would be to either have an independent person to help with the filling in of the form, or maybe a spell check would be good?</p> <p>10) See answers above.</p> <p>11) Yes but that healthcare professional has to have a real understanding of the abilities of the person in question.</p> <p>12) Yes as I said in the above answers there will be very different disabilities and also abilities so maybe the only way to find the right way would be to have a joint agency review to save time and money but to also include at that review representatives who can act as a person nominated by the disabled person if they feel unable to speak for themselves.</p> <p>13) This would be apparent with a joint agency approach, this should only be done with anyone who you feel or someone else feels there maybe a reason to do this. This should come from the second group, so as not to cause distress to the people in the higher group who it is obvious that their disability is permanent for life.</p> <p>14) Yes for some this should be explored but not against their wishes, for someone who although is quite physically disabled but is (normal) in every other way this would be an imposition, and against what DLA stands for and it would be a step backwards for some of the people who DLA is there to help, so proceed with caution.</p> <p>15) See above.</p> <p>16) Social Services and Health should supply aids and adaptations, and Mobility Allowance should be used for mobile aids outside of their home ie car or electric wheelchairs.</p> <p>17) I was a carer for 22 years before working with adults and children with a disability. Children when they reach an age when they would like to join maybe the cubs/scouts etc might then benefit as long as this money is used for this maybe a voucher system would work and could be set up through maybe a family support worker?</p>
ONLINE376	<p>2) that will cause unnecessary work for the claimant in filling out further forms and these are complicated enough now and does put people off</p> <p>6) I believe that being able to do things like hanging washing out and cleaning should be taken into account as my disability makes doing the simple everyday tasks more difficult and some days are worse than others depending what I have done, I have fibromyalgia and osteoarthritis and have had this condition for many years, if I overdo it one day by trying to do things around the home or shopping I suffer for 2 days after, I am becoming less able to do lots of everyday things as I get older but this is not taken into account with the help I receive, whilst I fully appreciate the help I do get I feel more consideration should be taken into account apart from personal care, I find it very difficult to get into kitchen cupboards high or low ones cannot use arms to long as causes extreme pain in neck and arms there are so many things like changing beds, things that we take for granted when we are healthy suddenly seem like a mountain to get over, so please consider some of these points when reviewing this system, without my husband around to do things for me I would be living in a dirty home</p>

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	<p>8) yes all aids and adaptations should be considered and if the persons has'nt got these to let them get help to get them, I have several items to help me and they are a godsend, like a bath cushion raised sockets frame around toilet ,ramps to get in and out of house easier</p> <p>10) A Dr who specialises in the condition or your own GP are the best people to access you as they know you and have full details of problems,also your occupational therapist. We already have to provide details from these people anyway on the forms</p> <p>14) If you receive PIP then I think you should be assigned to an occupational therapist, you will need to employ more of them to meet this criteria, I personally was not aware of help available from them until about 4 years of getting DLA, and then its only because a friend told me about it.</p>
ONLINE377	<p>1) lack of mobility</p> <p>4) having 2 rates is a possitive</p> <p>5) should be based on the individual</p>
ONLINE378	<p>1) Society's attitude towards people with disabilities problematic. We are peceived as 'non entities'Access issues are ongoing. Acceptance in able-bodied groups difficult as often no provision made for us.Told evening classes/social activities but often location and times do not suit people with disabilities with transport issues etc.Unable to lead full independent lives as dependent on others to do everything for me [wash/dress etc]Day centres closing so no means of gathering together. Community provisions inadequate</p> <p>2) Leave in main as it is but include provision for heating, prescription, dentist, opticians costs, and needs for maintaining the home [cleaning, gardening, windows etc], which should not be ignored when no means of providing income to meet these necessary and ongoing costs.</p> <p>3) Care issues. transport costs, help with household duties [cleaning, cooking, gardening, windows washing etc which as individuals we are not able to do for ourselves ,but are tasks that have to be done. Prescription costs. Despite receiving DLA still liable for cost os medication where pensioners get theirs free.why when our income restricted and probability is our medical costs are greater!Heating costs: as at home need more heating yet do not qualify for the heating allowance paid to pensioners, whose need may not be as great as ours.Discriminatory practice.Purchase of aids and equipment, which cannot be easily acquired through Social Services.Also have to pay for spectacles where pensioners do not, so already unfair and again discriminatory/disadvantages disabled people.</p> <p>4) I do not think this will be applied fairly as it will vary according to locality, the individuals ability to express their need, their GP's support and attitude towards their patients, budget restrictions and will cause confusion for those applying. People do not complete the DLA or AA forms as it is because the size and format are too cl=omplex for them to understand. How can you gauge level of support properly.</p> <p>5) Yes some should be automatic entitlement. I have friends who are severely disabled in wheelchair with brain problems. Because they insist on living independently they are only in receipt of middle care component. They are frightened of being taken into care so will not reapply for higher rate in case 'that which they have is removed from them'</p> <p>6) by providing sufficient occupational therapists to meet the increasing need of the service so that people with disabilities CAN maintain their independence properly. Not the poor service currently available.</p> <p>Any activity which means interaction with other people outside the home is good TO STIMULATE AND MAKE THEM FEEL AN INTEGRAL PARYT OF THEIR LOCAL COMMUNITY. Again there needs to be a service in place to provide this eg: Adequate transport, social clubs which can cater for disabilities, carers, accessible/adapted buildings etc</p> <p>9) Make the form much easier and basic by using easy to understand language. Do not repeat the questions several times in different ways, which confuses people applying. Make it smaller and more user friendly. The current form frightens people as it is set out in such a way as to be offputting. People with learning difficulty in particular, or sight impaired will have great difficulty understanding it let alone answering /completing it!</p> <p>10) Doctors and specialist[s] info plus anything from physio,optician, hearing clinic, occupational therapists, community workers, family/freinds who look after the client etc together with history of problem from client which gave rise to the claim.</p> <p>11) Dependent on individual may be offputting. People with learning difficulties like familiar faces to relate to.Face to face may confuse some people. Some people do not like strangers in their home. If health is one which 'varies' may be difficult to assess the</p>

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	<p>impact'long term affect the medical condition has on the patient.Also depends on approach the professional has to the individual.</p> <p>12) No idea.Perhaps by asking GP to monitor individual health care needs and submit returns noting any progressive change in condition? Certainly think needs to be no more frequent than three years, as per current DLA award.More frequently would add an unfair workload to the medical profession. Use information from professional bodies seen during that time, general health patterns, contact with individual to fill in a review form, but much simplified version possibly every three/five years</p> <p>3) If the form is made much simpler, with no jargon,so people can easily understand it, have a BOLD, simple, statement at the beginning or at the point where you sign the form stressing the need to inform of any changes in medical condition. Perhaps inbuld a paragraph in the annual letter sent out which gives the increase in benefitrte to remind claimants of the need to notify any change</p> <p>?) A lot would go without as they couldn't afford to pay for the things, or provide the services they need themselves.However much greater awareness is needed as many only discover they are eligible for grants, other services etc by default/accident, or through a third party.</p> <p>?) As much information as pssible to not only ensure people DO claim the benefit to which they are entitled, but also so they are aware of what is entailed, how it will benefit them, how they qualify, what the changes are to the existing DLA scheme, what they need to do etc so they are aware of what is happening, what information they need to provide, how the 'scheme' will work etc.</p> <p>?) By using savings, their DLA money, or borrowing [loan] A freind recently spent over £2,000 on a motorised chair so he could get out and about on his own. He lives alone and in order to be part of the community has to be able to get out into it! He should not have had to buy this it should have been provided by the State. I had to buy a stairlift at £2,100 on my credit card so I can get up and down stairs. This should have been paid for by the state as they want me to remain independent yet will not meet any cost towards achieving that.The PIP should be available to meet those costs</p> <p>?) Insufficient knowledge on current procedure to know what else needs to be taken into account, or info on the different equality groups.</p> <p>17) Not able to comment as I have no dealings with children with disabilities and do not know how they are currently assessed</p> <p>8) The current assessment can be insensitive and intrusive.It makes genuine people feel aggrieved as they have to 'jump through hoops' to get their entitlement. There is still a stigma attached to my generation, and earlier, about applying for benefit. Today's society appears to be a 'benefit culture'who see it as their right to claim for anything and everything irrespective, which is what has led to the current financial crisis, and amendment of pension age which adversely affects me THIS YEAR, yet I worked and paid into the system for my pension, unlike many today, and am being penalised for doing so! The changes proposed to DLA will have an adverse affect on the majority who are legitimately entitled to claim. The GP should be first point of contact re claimant's history.</p> <p>11) This is vital. the people used need to be independent and have an empathy and understanding of people's need [physical and mental disability]Currently people find out about things by default or word of mouth. Information and advice need to be more readily available and well publicised to encourage attendance/take up. It is probably better in clients own home as they are more relaxed and have access to information which may be required. An element of trust has to be built up before they will 'open' up with what you need, so ADEQUATE time has to be allowed for any visits to encourage a claim and gain information required. May need more than one visit as concentration spans vary, as does ability to take on board what is being said.</p> <p>(9) Too few people know about it, or the impact failure to participate in your survey will have. This should be widely advertised to ALL disability groups across the country with timescale for informed discussion/comment/feedback. Not a 'back door' way of introducing new legislation without proper consultation exercise with all professional and disabled people, their carer's and families who are the ones who will bear the brunt of these proposals which may well be detrimental for them.</p> <p>18) Vital importance. Without the income provided through DLA I would not have been able to apply for a warm front grant for Cavity wall and loft insulation 4 years ago. As my husband is a low earner we would not have qualified for a small working tax credit if we did not have the 'disabled' element.The blue badge has also helped when parking in town</p>

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	<p>where parking is very limited. I do not qualify for Council Tax refund, heating allowance, free dentistry, optical or prescriptions, which I feel should be included, as retired citizens, who may be much better off than us, automatically qualify for these things because of their age. This is discriminatory.</p>
<p>ONLINE379</p>	<p>9 ) As someone who receives D.L.A for a developmental disability (Asperger's Syndrome which, as I imagine you may be aware, is a mild form of autism) I would say there should be just as much emphasis on those sorts of disabilities as, and they should be seen as no less important than, PHYSICAL disabilities. When I first applied for D.L.A. I did so on the grounds of a MENTAL HEALTH disability; I found the form did not enable me to express how this affected me, and why I therefore needed D.L.A., so I attached a written explanation of this (something someone less able to express him/herself in writing would have found too difficult) but because your definitions of the conditions needed to qualify are (or at least were) so rigid I was only able eventually to access the Care component by claiming on the ground of inability to prepare a proper cooked meal; and I was only able to do THAT by relying on my Asperger's: the fact that my Asperger's evening routine means I can't spend more than 30 minutes preparing the meal. I would therefore contend that the forms, and - ESPECIALLY - the CRITERIA, should be FAR more flexible and attuned to individual disabilities rather than, as seems to be the case at present, what I call "little boxes" in which claimants either do or don't fit. And I repeat my point about MENTAL HEALTH, especially, and also developmental disabilities (not just autism but also A.D.H.D. and similar conditions) being given as much importance as physical.</p> <p>Finally the form should be MUCH easier to complete; I wonder how many potential claimants are so daunted by it that they don't even bother claiming! And if the award is for a specific period the "Claiming Again" form should not be as long and complicated as the original form.</p> <p>(19) It would, fairly obviously, mean they were worse off! I would therefore state, most strongly, that it should be MADE possible for it to be used as such a passport.</p>
<p>ONLINE380</p>	<p>1) They face a range of barriers like:  * ability to socialise , * confidence to socialise * obvious physical effects of their condition * stress and anxiety * mental wellbeing It is not just the physical issues which affect disabled people.</p> <p>2) The three tier system. and indefinite awards</p> <p>3) Disabled people face a range of additional costs that could include:</p> <ul style="list-style-type: none"> <li>* additional transport or living costs</li> <li>* additional costs on home moving, decoration etc because they may be unable to do these themselves (DIY) like a normal person could</li> <li>* additional costs relating to frequently visiting the hospital or GP etc</li> <li>* additional costs because of specific living aids which are required and may not be supplied by other means</li> <li>* additional food costs in the case of some chronic bowel conditions</li> </ul> <p>4) I believe it should have three rates. As the new system will either be lower or higher rate. What about those people that are in the middle benefit now -that means they will reduce to lower benefit. That is unfair and unjust.</p> <p>5) Yes they should. This should be an automatic minimum entitlement to benefit depending on how severe the condition is it may need to be higher than the minimum.</p> <p>7) I believe that conditions that vary and fluctuate cause such a nuisance to individuals that they should be treated favorably. For example if the person is borderline low rate and middle rate they should receive middle rate because living with a fluctuating condition can be very difficult.</p> <p>You can't make plans even when you're well for fear things may flare up. You're unsure if you'll be well the next day etc. You can't assess benefit every day and pay by the day.</p> <p>8) I believe it shouldn't take into account this. Aids help people but they don't solve the problem like some professionals believe, they merely help the patient slightly. There underlying condition remains.</p>

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	<p>10) I don't believe that GPs are best placed to comment on the affects of a condition. My GP only sees me for routine issues - they're not aware of how often I see the Consultants at the hospital or what the affects are on me. They simply sign my repeat prescriptions. I believe this should always come from a Consultant or someone sufficiently involved in the persons care.</p> <p>12) I believe that indefinite awards should remain. This will alleviate some of the admin burden on DWP and mean fewer staff and saving money. Some conditions will always stay the same and the best that can be hoped for is a good spell where the condition is more controlled though the individual is still entitled to DLA at this point.</p> <p>I see no reason why it should be necessary to form fill every year.</p> <p>13) I believe what would prevent people from doing this now is because if a condition improves they would face an immediate drop in benefit. Could this not be done like other back to work benefits where the entitlement continues for a few months to allow the individual to see their condition improve and find another revenue stream (i.e. employment etc) t replace the benefit they will lose from DLA.</p>
ONLINE381	<p>1) Having two childen with severe autism, the youngest in residential school home alterate weekends and holidays the eldest boards Monday to Friday, home every weekend and holidays if mobility component is taken away it leaves me with no transport as I have a car on mobility, I would be forced to take the eldest out of school to maintain transport for my two disabled children, surely this is not right.</p>
ONLINE382	<p>1) Personal disability whether physical, emotional or psychological.</p> <p>Access to transport and buildings.</p> <p>Attitudes of disability by some people are belittling.</p> <p>Access to services and adaptations / equipment.</p> <p>Access to rehabilitation facilities VERY poor, especially for younger adults.</p> <p>2) Access to motobility vehicles, a vital requirement for disabled people to get around</p> <p>3) Purchasing extra care.</p> <p>Property adaptations adding downstairs toilet, stair lifts</p> <p>purchasing additional aids - mobility scooter</p> <p>bigger heating bills as at home more.</p> <p>purchasing help with cleaning, garden, window cleaning etc</p>
ONLINE383	<p>3) Disablement means having to pay highly for every household maintenance job, DIY is not an option any more. As a low earner I cannot afford to buy a decent bed or re fit my 1970s kitchen to suit and am finding life pretty uncomfortable. All my higher rate DLA is spent on keeping my '98 Corrola on the road to get me to work and shopping. I would love to move back up the earnings ladder but get so easily fatigued these days. My daughters comming uni / maintenance fees will be the financial'crippler'.</p> <p>5) Spend a day or two at a large Tesco store to see the beautiful people jumping out of their 4 wheel drives, parked in disabled bays with a prominent blue badge and in some cases VED. You can easily spot the most needy as they are the ones hobbling about on low wages driving modest cars and shopping frugally. I would frankly make the benefit means tested as I beleive it is being abused by the 'Thatcher' generation (selfish opportunists).</p> <p>8) I have osteo arthritus in the vertebrae, limbs and pelvis, I have good days and bad days. The only aides I use are a stick, shoe horn and grabber. If I relied too heavily on aides I would seize up and limit my ability to work. This does not mean that I struggle to walk and am constantly in paain. I woulod certainly appreciate an orthopaedic bed as I dont get much sleep. Unfortunately I'm in a category where I earn less than £18,000 but have to pay for everything (apart from what I can afford on H/R DLA).</p>
ONLINE384	<p>1) You must ask them! It is going to lead to great injustice to use an objective test. As you acknowledge even two people with the same condition have different needs. If you are</p>

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	<p>going to rely on e.g ATOS, then you will certainly not be being fair. In my own experience, 2 different ATOS advisers, 3 weeks apart came to different conclusions as to whether DAL applied to me. I suggest a combination of objective and subjective analysis (if you can really afford it!), but with extra weighting for the subjective.</p> <p>2) As above, you must keep a strong element of subjective analysis, that is assess the individual's needs on the basis of what THEY say. If you are going to introduce 'objective testing', then you must publish the criteria and guidance applied by not only the decision maker but also any DWP instructed professional, such as ATOS. You also need to explain more fully the transition provisions. Is it fair to someone on the highest level of support to have this suddenly removed. You have said that the current DLA criteria are not well understood. This is an admission of poor training to DWP staff as well as failure to publish clear guidance to the public. Before you change ANYTHING these issues must be addressed and you need to say how you will do so, and how you will finance the additional training and publicity.</p> <p>3) What a disingenuous question! Surely each case is different, but the fact that you are retaining the Care and Mobility components shows that you are at least aware of the main issues. I will add one more. Financial Security, as part of the wider state of Peace of Mind. Your proposals are doing much to undermine the sense of financial security for thousands of needy people. They already face a future without being able to contribute to pensions or savings. They have to live day to day and hope that society will be fair. Please address these issues in future drafts of the consultation document.</p> <p>4) Of course not! How can this be consistent with dealing with each person according to his/her needs? You are of course saying that you will be withdrawing the lower rates. How are those in receipt of these expected to make up the difference?</p> <p>5) The latter</p> <p>6) Firstly you will need adequate staff in both numbers and knowledge. Apart therefrom, you must ask the individual.</p> <p>7) As question 6. realistically you will not be able to properly review each case more than annually. You will have to rely upon individuals reporting changes in needs. You must make this a sensitive and easy process.</p> <p>8) They should be taken into account, both those used and those available. In the latter case, you must have a sensitive and easy process for the individual to report back on the success or other wise of the aid. Also, unless the aid can be tested within 4 weeks, then the assessment must be on the basis on no aid until and unless it is installed and approved by the individual.</p> <p>9) These questions are premature until Parliament has decided upon the changes. You can, of course, make a start by trying to simplify the DLA claim form.</p> <p>10) Each case will be different but, as a general rule, the individual claimant is best placed. As you note in the Consultation document the individual knows his/her condition best. Some are even experts in their condition. Next would be the GP or Specialist/s in charge of providing care and any carers. Quite what purpose a face to face meeting with an ATOS doctor/nurse will contribute I fail to see. In particular, such a meeting should not be expected to undermine the claimant's or his/her medical adviser's assessment. But that, I fear, is what will happen.</p> <p>11) Please see question 10. If such a meeting is required the claimant should be provided with full details of the qualifications and expertise of the professional, including their time in practice and any knowledge gained through practice of the condition/s of the claimant. The claimant must also be provided with the information with which the professional has been provided by any other party.</p> <p>12) Point 1: 12 monthly or longer Point 2: Of course, but with a minimum of 12 months</p> <p>13) You could e.g send a reminder to each individual at 3 monthly intervals. This must be signed and returned with a certificate of no change or request for further assessment. If it is not returned follow up with email, text or phone call.</p> <p>?) See above about training and publicity</p>
ONLINE385	<p>5) I feel that its not cost effective to review all conditions, there has to be some common sense appraoch, some conditions are so obvious, we need a sensible approach, which does not put the most deserving customers through a process which is unnecessary.</p>
ONLINE386	<p>1) In terms of getting employment I think the laws governing recruitment and specifically filling in job applications should be changed. Currently if you have a medical condition you</p>

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	<p>have to declare this on any job application. Even if this condition does not affect you any more. How can that aid equal employment opportunities when employers can dismiss potential applicants based on their own prejudices even before the interview stage. I also think you should remove the declaration of disability for the same reason. People should be recruited on suitability for the job and removing this would both prevent positive and negative discrimination in employment. I also dislike the fact that you now also have to say what your sexual preferences are on job applications. Even though I am heterosexual I find this offensive. Again what difference does this make to being able to do the job? And recruiting on the basis of sexuality - positive discrimination is the same as negative discrimination, and I really doubt employers aim to recruit people because they are disabled etc - which is what this positive discrimination intends.</p> <p>10) The doctor treating the individual. For example if someone had a mental health condition, they would be entitled to less because they have no obvious condition, and no need of apparatus, however this person may not be able to drive, not be able to leave the house, and not capable of working. It would be disappointing if such cases became a victim of this policy change, just because there is no "visual evidence" of disability. Such people need the help of social workers to get back to a normal life. I fear however this policy would disadvantage this kind of disability.</p>
ONLINE387	<p>1) My wife is mentally ill and in the past, before DLA, it was very difficult to be able to take her to any activities or required therapy. Although I was still her carer I still needed to be seen to be looking for work and a number of times my wife had to miss important appointments, therapy and treatment because I had to attend the Job centre, even though the Social Security new of my wife illness.</p> <p>2) I do not believe that anything about the DLA should be changed.</p>
ONLINE388	<p>1) Lack of understanding of how our disabilities affect us day to day- especially if our disabilities aren't immediately obvious to the public.</p> <p>lack of imentiites for the mentally ill, not enough support within agencies and waiting lsits far too long to deal with social phobias as well as limitations getting out when you suffer with a physical disablilty.</p> <p>2) All rates!</p> <p>3) Transport Taxi's</p> <p>Fuel for motability vehichles</p> <p>Extra Fuel costs for the housebound</p> <p>Special dietary needs</p> <p>Specialist clothes and footwear</p> <p>Outside home help ( not social services)</p> <p>Specialist adaptions to make life easier in the home</p> <p>10) Our own GP's consultants and mental health agencies who know us the best and how our condition affects us.</p> <p>11) The whole process is terrifying for many sick and disabled , and makes us even more ill with worry . Many of the agencies who have conducted the assessments do not have a clue and claimants are made to feel like a file number not a hum,an being. People who suffer with mental health issues find it difficult dealing with agencies that don't know their own personal conditions and also suffer with dealing with strangers both in or out of the home enviroment, and some can't even get to the centres without feeling traumatised as they don't want to leave the house. All outside assessments should be recorded and a copy provided to claimant</p> <p>12) indefinate or life should be left at that, DLA is not an easy benefit to get and causes many so much stress it excelebrates disbilities and conditions, mental health assessments should be executed by mental health specialists outside reports from support workers. psychiatrists to be used as individual case merits who know how social factors affect people with mental health issues . Specialist asesors used for the disbaillities in question, rheumatologists, orthopeodic, cardio etc.. not generic GP's sent out to assess</p>

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	<p>?) For some claimants this would be devastating.</p> <p>?) Some people can get adaptations via social services but there are long waiting lists, household aids that can help around the house are usually funded by the claimant and these can be expensive.</p> <p>?) The proposals have to be fair , don't assume that disabilities are people in wheelchairs or bed bound, many are not seen are people are accused of not being as disbaled as being reported. If you are giving financial reposnsibility to our GP's then give them some credit and take their word that patients are as disabled and ill as they say, especially when they provide you with consultants reports and outside agencies involved in cases.</p>
ONLINE389	<p>1) Lack of awareness and in some cases willingness to understand what being disabled really means and how it affects every part of everything that happens on a daily basis.</p> <p>Also, a lack of facilities and resources. Children with complex needs are expensive!</p>
ONLINE390	<p>4) My 20 year-old son has autism, and the current criteria are wholly inappropriate for this condition, as they are focused more on 'physical' disability. So, my son can walk on level ground, without pain, etc, etc, but he has never in his life been outside alone without supervision and support, and yet under current rules this is not rated as a high level mobility problem. Also, although the current system has separate 'care' and 'mobilty' components, these components are linked together at the top level. This means someone cannot get the highest level of mobility allowance unless they are also receiving the highest level of care (i.e. they require care during the night). There are exceptions to this, but the burden of proof is enormous. What does a night-time care need have to do with a daytime mobility need? I would hope that any new system would address these issues.</p> <p>17) My son has autism and he is approaching 21 years of age. He has never been outside alone without supervision or support. One might expect a young child to need such support and supervision anyway, regardless of any disability, but not an adult. When trying to have his DLA reassessed to a higher level, I was asked to explain how his condition had got worse. In fact, it had not got worse, it was just that the degree of support which he needs has become 'age inappropriate' now that he is a grown man. I would hope any new system would take account of the 'age appropriateness' of any required support.</p>
ONLINE391	<p>1) people with learning disabilities are more disadvantaged when it comes to employment.</p> <p>people with learning disabilities are not always able to access public transport and if they are able to do so cannot without a carers support</p> <p>2) keep mobility component for learning disabled people living in registered homes - this is vital to their independence</p> <p>3) having to pay for taxis or dial-a-ride to get around if they are not able to access public transport independently the main costs that disabled people face is transport costs as not all by any means are able to access public transport independently</p> <p>4) two components are ok as long as the mobility component for those living in residential placements is kept as this is VITAL to ensure that that they also have the ability to lead independent lives. Most residential homes for ;learning disabled people cater for a small number of residents (up to about 10) and DO NOT have their own transport.</p> <p>6) people in care homes NEED the mobility component to continue to enable them to lead full and active lives. To deny them this is an infringement of their human rights!</p> <p>6) people in residential placement NEED the mobility component to enable them also to lead full and active lives. Why does the coalition believe that people living in residential homes do not need tthe mobility allowance. it is an absolute MYTH that transport costs are paid for by the LA!!</p> <p>8) disabled people have more than enough difficulties just living dat to day - NOTHING should be taken away from them if they are genuinely disabled</p> <p>10) from the claimants OWN GP</p> <p>10) letter from clients own GP</p> <p>12) if somebody is either physically or learning disabled from birth and doctors know that there will be no improvement why continue with costly assessment.</p> <p>12) if someone is disabled from birth what is the point of continuing assessments?</p> <p>13) include easily read literature and a stamped addressed envelope</p> <p>?) information could be shared between many agencies IF it means that the disabled person will receive ALL benefits due</p> <p>?) please do not take away the mobility component for learning disabled people living in</p>

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	<p>registered homes. This will have a huge adverse affect on their lives and will commit these people to rarely being able to go out and access the wider comminity as they will be left with just approx £22 per week to pay for EVERYTHING apart from thier rent and meals. How ccan they also pay for transport from this - could YOU?  ?) your proposal to withdraw the mobility component for learning disabled people in registered homes treat these people unfairly. why are people living in registered homes not able to lead independent lives and why are they being unfairly discriminated against?</p>
ONLINE392	<p>1) SEND THEM A FORM WITH DECISION LETTER  2) THEY NEED TO KNOW WHAT GROUP OF PEOPLE ARE ELLIGLE FOR THIS BENEFIT.  YES.  3) SUPPORT AND ENCOURAGE WOULD BE HELPFULL.  4) WITH HELP FROM L.A.</p>
ONLINE393	<p>1) Full acknowledgement by service providers and the public that a disability should not prevent many from fully participating and engaging in decision making about how to live their lives - from social, health care and inclusion view points  2) If a person has been awarded DLA for life, or similar, term - this should remain their status, and they(or their carers) should not have to return to completing interminable forms which they find distressing and taxing  3) Transport/mobility costs are a considerable drain to those without mobility, and this is especially so when a person lives in a geographically challenging area which has no alternative to privately funded transport. It is not at all useful to suggest a person moves house to resolve this, as often their support network is nearby or living with them. Mobility allowance helps the person to retain essential independence for as long as possible, and their geographical circumstances could perhaps be considered when making the award.  5) Automatic entitlement would allow those affected to receive financial support for which they may be wary of applying - not everybody is comfortable with completing lengthy forms, feeling there must be 'a catch' and they could be subject to scrutiny. User-friendly application forms might alleviate this.  8) I am aware of situations in which a child's parent is asked to purchase speciality, purpose made footwear for a child with worsening deformed feet; either these must always be freely available, or funding must always be paid through benefits. A child should never go without suitable footwear because of beaurocracy  9) perhaps a supportive charitable agency could be funded to assist those requiring help to complete the form.  make it clear to those already in receipt that they will be fairly assessed for the new benefit; there exists a feeling that repeat DLA applications have been routinely  10) It is my experience that an independent professional often is unwilling to take the time to fully assess circumstances, which can be complex. A GP may, as suggested be the right person to do part of an assessment, although they do not always fully understand some elements of their patient's daily life and needs.  11) Personal experience of having to visit an independent professional in town has proven to be difficult, because of accessibility and parking etc. Perhaps home assessments are more realistic and allow for better overview of daily challenges  13) a yearly postal reminder  15) this should be a totally independant system and not answerable or part of government office  17) be sensitive to parent carers who are having to apply on their child's behalf - some find it difficult to self-assess how much their child's condition is truly impacting on their life - they then put insufficient info on the forms and are not awarded sufficient level of support benefit</p>
ONLINE394	<p>1) Perceptions of 'Disability' are often wrongly limited to the belief that only a person using a wheelchair or a white stick or showing clearly seen mental &amp; physical impairment deserve the label of 'Disabled.' Some disabled people look normal and fit but have heart-problems;chronic pain; asthma; ME or MS for example. Access is very difficult for wheelchair users or walking disabled, especially beyond ground floor, even in new buildings! the failure to realize that tiredness makes it impossible to work for more than a few hours; pain killers or other meds may only help ease rather than remove pain; getting ready to leave home can take 1-1.5 hrs for most disabled people, so to be at work for 9am is an impossibility. Being active on one day can mean resting for most of the following day.</p>

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	I can be independent only within defined awareness of care and support. Government, medics, society needs to value disabled people without trying to make them conform to 'normality.'
ONLINE395	<p>1) Clearly the physical ones and the many problems of access and available assistance, but there are social barriers - the disabled child will not be befriended by others of her own age unless the mothers share a similar grief. The same applies throughout life - there may be the odd old lady in the street who will invite a disabled person in for a cup of coffee, but, to be fair, all the younger people in the street will be out working (forced to keep up with the Joneses) and relying on some one else in society to care for their own children - how Bowlby would have been disappointed. Who will invite a handicapped person to join their group in a pub (or charity) quiz? Who will suffer the possibly interminable babbling of the disabled, or the wandering old? When clubs are formed locally for disabled children or for mixed groups how long is it before the only helpers remaining after a few weeks are the parents and probably only the parents of the disabled. The advice given to veterans probably true - the disabled will find sympathy in the dictionary - between s*** and syphilis. This is not a question of class - it is fairly universal. Of course there will be economic barriers, educational barriers, etc but the social hurdles will by and large remain and the best solution for many disabled persons is some sort of ghettoisation - within housing estates, for example, warden supervised. In the old days people used to classify special schools as sited on certain models (probably unfairly) such as the Kent model (in a glorious old country house far away from everyone) or elsewhere as the school down at the bottom of that housing estate and even on an integrated campus likely to be the furthest from human communication. Integration in schools has not really been successful, apart from children of voraciously eloquent parents, a vociferous minority.</p> <p>2) Everything. The opinion of one of the Old Guard who fought for handicapped children in the Sixties. These changes could seriously affect the multi-handicapped in our society if untrained and inexperienced persons are involved with any assessment which should be far more comprehensive than the document suggests. For the multi-handicapped nothing less than a full multi-disciplinary board (?) would be satisfactory. Otherwise deep psychological damage could result from amateurs entering the field. I understand that a fortnight is allocated for disability in the 3/4 years training of doctors, most of whom would accept their inability to get it right unless they have long periods of contact with the person they are assessing.</p> <p>4) Are there not two rates at the moment?</p> <p>5) My dealings have largely been with the congenitally multi-handicapped and I fear for their situation if these proposals were universally applied. They have a "passport" to as fine a life as can be made for them, and not subjected to the possibility of misinterpretation that the proposed system might allow. There is often a degree of "slowness" in this group. Of course there are others why should "heroes" whose lives have been shattered in conflict be "put through the hoop" of assessment, review that used to obtain back in the Sixties - many of us had hoped that this nonsense had disappeared and it is sad to see the suggestion of revival of an antedated system. Annex 1 nowhere covers the list of deteriorating conditions that should be given automatically entitlement - sitting for five minutes and thinking will produce an extensive list known to most people - see my final comments,</p> <p>6) Whatever YOU, as a "normal" human being think essential. To take one matter only - what do YOU mean by mobility (ignoring the benefits of the car). How do you build a model I have always suggested: making one's way to the local railway station, taking a train to the nearest mainline station, changing platforms (by overhead bridge or lift) taking the train to London, changing to the Underground (or using buses) to reach the embankment, and then proceeding to the Houses of Parliament to take tea with your MP (and of course election. see Coming back) - or any other journey from the provinces to anywhere in the capital - little bit different from the old antiquated ideas of appropriate mobility for the disabled. If YOU were disabled, which would you think was the moral</p> <p>7) Make sure that proper assessment of all factors is made. The condition of the congenitally handicapped doesn't really change, nor does that of those clearly "on their way out", whether in weeks or years.</p> <p>8) It is my experience that any aids of quality are too often bought and donated by charitable groups. These groups are likely to have diminished funds in the near future, but why should any assessment question the background to such donations. They should rather be made unnecessary through support and supply of first class aids. Where people need wheelchairs or prosthetics they should be supplied simply to give the disabled person</p>

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	<p>some "normality".What should be asked is - can with these aids make that journey from the provinces without.Much of the concept of mobility that seems to be understood in the document is blatantly discriminatory.</p> <p>9) The forms are difficult and generally are filled in someone in a support service.It is difficult for someone who is capable of filling in forms to understand that others do not have the capability,and may never have (cycles of deprivation,etc)to fill in such forms and that they are afraid of them,particularly if they are prefaced in "six foot letters" "if you do--- or don't do ---"</p> <p>10) For the protection of the applicant,the assistance of some interested party,in support services or as advocates,Citizens Advice Bureau would be sensible as the consultation document does convey an element of threat in some aspects,such as assessment (by whom?),review after review,etc - it used to be like that for children,even when they were congenitally handicapped.A completely retrograde step.</p> <p>11) Who would be the healthcare professional ? Someone hopefully with years of experience in the world of handicap/disability/whatever facet is demanded.For the multi-handicapped nothing less than a full multi-disciplinary board would be appropriate.For the people I would make representations for such a group should include a neurologist and hopefully a neuro-psychologist and perhaps even a neuro-psychiatrist.I would remind us all of that lad whose mother's appearance on TV brought this consultation of so many people's notice.For the list of persons whom you say you would consult,there is no mention of carers,appointees,agents,parents or the disabled themselves,which latter should always be the first consideration,preferably with an attendant advocate.</p> <p>12) How,indeed.All or nothing - every year,every month,every week - of every five years on the anniversary of the claim.If a properly qualified body makes the original decision,there should be little need for review,that is to say,get the original assessment right,then the problem should not arise,although there are some handicaps where effects fluctuate,but they should not be marked out for special attention,but rather understood.</p> <p>13) Doubtful.The idea might seem reasonable to middle class educated (mainly now to degree level)persons,but a great many disabled persons are not in that social category and the proposal reads like an imposition.There have been as many cases of misunderstanding of regulations within parliament as there are in the world of handicap,it is reasonable to suggest.What was the phrase of Juvenal ?</p> <p>?) Any aids of quality are currently the gift of charities,whose existence may be endangered as the spare cash of the majority is diminished.Admittedly things have improved and no longer do local clinics offer "Victorian" bath chairs and the like,as they did in the sixties.Currently provision is made from government warehouses and is of reasonably good quality (economy style,perhaps,but this might vary from area to area - expectations may be higher in affluent areas,but this sort of thing has not been researched in any depth.The seriously disabled should be entitled,and it should be realised that the disabled (being Clumsy) may require replacements quite often - this was one of the reasons for allowances in the first place.I suppose this suggestion is a magnification of the "bunch of grapes at Christmas" philosophy.</p> <p>?) Clearly the nature of their problem - CPs,SBs,MDs and so on present different difficulties in a purely physical sense,and,within the major handicaps there are often several differing groupings - ataxic,athetoid and so on.Then there is so often the matter of associated brain damage or disfunction,when a plethora of differential diagnosis may apply.Sadly there can be vast differences of social standing where,for example,children from care homes for social reasons get the not so nice end of the stick.There is no perfect brain - we all have problems - it is the serious nature of any particular person's mental "affliction" that has to be understood and considered.The difficulties are infinite,and need specialist consideration.</p> <p>?) Clearly the uninformed might be able to represent themselves.For example in the "face to face" confrontation that seems to be suggested,severely disabled people may not act naturally.The interrogator,if a sole person was involved with the limited criteria that might well be set out for his/her use may not be sufficiently trained to identify "passing",which is common enough - the disabled person may feel inadequate and have been encouraged in this delusion by previous experiences and endeavour to impress.We have only to review the cases where it is any mentally handicapped person who may be near the scene who becomes the immediate suspect.If the interview is to determine the future of the handicapped these matters need to be addressed.</p> <p>?) I have probably said enough,but I might add a parable - in my more active days I felt that</p>

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	<p>each and every child in a mental hospital hospital should be in more appropriate care (and indeed adults,although some of these might have become too institutionised).Reflection and working alongside the very caring staff in those hospitals made me understand the comment - Not everybody wants to demolish the monastries.In too many areas the proponents of that maxim were proved correct in their fears.There just seems to be too much change and alteration taking place for yet more to come along for alot of people,who are tending to question what it is all about.The timing is wrong.The idea of a need for change is wrong,because whatever system is in force it is no time until exceptions,other considerations,special cases come along -as indeed the consultation document itself suggests.I have no doubt that there are good intentions behind the originalidea but cannot but feel that it may be "hijacked" by economist's interference with a laudable conception.It is difficult to see real improvement inthe suggestions and some are morally indecent (the multi-handicapped child in the care home).The whole attitude seems to be "they" must have procedures that "we" can control,butperhaps deprimentallywhere it should be how can "I" help "you",looking upon you as an equal,which is supposed to be the philosophy behind the original idea.I cannot see anything that will deter the nasty imposters from taking advantage, but am concerned that so many already suffering should have added concerns - Ossa upon Pelion.I may take anarrow view of these matters but my concern is for the multiply-handicapped,the crippled or socially,physical or emotionally impaired older person.Annex 1 does not embrace the sufferer fromParkinsons,multiple schlerosis,osteoporosis,hypothroid difficulties,and dozens of other debilitating complaints that multiply as the individual grows older and the demographic pattern increases this burden - upon the poor devil who is unfortunate enough to be afflicted.The question is - what can we do for them to make their days more comfortable and how should we encourage them to enjoy life as much as we can,where are are the normal.Humanity calls for the use of the yardstick rather than the application of the micrometer.</p> <p>?) If a centre which could house a multi-disciplinary team could be established ( i.e. withits own records) then duplication could be avoided - not always easy to achieve not because of bureaucracy but from differing philosophies.In terms of this exercise political bias might also determine approaches which might interfere with the role of the professional.(in the field of Economics,for instance.</p> <p>?) It might have been an idea to send out to every individual in receipt of DLA a copy of this document and then you could have had your answers,as it were,"from the horse's mouth".If you issue a comprehensive public notice and send that out to every claimant any problems might be addressed immediately,probably after the claimant has sought advice,if possible,"among his own".There will certainly be a lot of fear and anxiety,which may even now gaining impetus - at a time when Government seems to seek change in every single thing.What advice do you give the threatened ?</p> <p>?) Probably most of the increase in the number of DLA claimants has been due to their learning of the possibility through support services and charities.The informationhas always been there in the form of public notices,but thereare a large number of people who cannot read,and certainly not comprehend.There are newspapers who write thinking of people with a low reading age - they might help in the appropriate dissemination of information.</p> <p>?) Response reserved for some future occassion.</p> <p>?) Surely this is not a possibility ?</p>
ONLINE396	<p>1) By informing them of the importance of keeping us informed, highlighting the possibility of overpayments.</p> <p>Perhaps also by sending out correspondence regularly, asking them if they have had a change of circumstances.</p> <p>2) I do not know what Personal Independence Payment is so i cannot answer this question. I suppose if they are entitled to it, then it would be helpful for it to be provided as part of the process??</p> <p>3) I don't know!</p> <p>5) For what??</p> <p>6) I don't really understand the question!</p> <p>7) Not sure.</p> <p>8) Don't know!</p> <p>9) I don't know, i don't really get the question!</p> <p>10) No this is a waste of my time!!! I have just written a response which was over one hundred words and the stupid system has thrown me out. I do not have time to write it</p>

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	again as believe it or not, i do have work to get on with!
ONLINE397	<p>1) Activities of daily life take longer(problem) to perform and in my case a moderate to severe pain level (problem) is usually present. When pain is not present I can be guaranteed it will be the next day if I do too much on any particular day. This impacts dramatically on my mobility (problem) and my capacity to walk more than 50m or so (again on a good day I may be able to walk 200m given the time to do so, but I know that I will be in severe pain the following day). In addition my balance is not good (problem) but hydro therapy and regular swimming helps me to keep fit enough to work. Sadly after redundancy consultation I was offered a part-time (17 hours per week) job but I spend my remaining hours volunteering. My bones might be shot but my brains are ok €“ yes humour does help!</p> <p>I have to get up early (5.40am) so that I am ready to go to work on time. Medication has suppressed my immune system to such an extent that I cannot travel in crowded public transport (problem) hence I have to travel by cab or car.</p> <p>Early starts (problem)and taking longer to get places and do things (problem) puts me at a disadvantage.</p> <p>One of the biggest barriers is mental attitude (can be areal problem for some people). Yes I do get depressed but I take my medication as prescribed and I belong to a support network so I don't feel isolated (real problem for some people). Because I have stayed in employment my skills are up to date but lack of skills can be a real challenge (problem) to some people.</p> <p>3) Cost of care and assistance with the activities of daily life can be very high. Transport costs are higher in many instances because public transport is not suitable. Modifications to the home, many of which are not covered by Council grants, have a huge impact on people s ability to maintain their independence. There is an extra time cost for people in work because it takes them longer to get ready for work, to get to work and in some cases to do the work which puts them at a disadvantage in the current labour market.</p> <p>4) It will certainly be easier to understand but I worry that some people's needs won't be understood or accommodated in a 2 rate system.</p> <p>5) Automatic entitlement would decrease administration costs but degrees of severity do vary within conditions so all claims should be based on the needs and circumstances of the individual applying apart from those with terminal conditions.</p> <p>7) This is very difficult to administer cost effectively and fairly. Perhaps a simple review every 2 years by way of a short questionnaire from an expert medical person would suffice.</p> <p>8) Mobility aids such as a stick or sticks, crutch or crutches, braces, self propelled or powered wheel chairs and automatic or adapted vehicles.</p> <p>Domestic aids and adaptations such as ramps, handles, taps, switches, telephones, cutlery and other culinary tools, showers, bath aids, chair lifts etc</p> <p>Work aids such as adapted computers, office equipment, desks, chairs etc.</p> <p>Additional aids and adaptations ought to be considered because they might make the applicant more independent with a better quality of life and maybe more independent financially.</p> <p>9) A shorter claim form with the option to complete it on-line would make it much more positive.</p> <p>Simple bullet point criteria which are clear and concise.</p> <p>10) Medical specialist - not always the GP. Medical specialist could include a specific disease consultant, physiotherapist, occupational therapist and maybe an independant assessment centre in some cases.</p> <p>11) People living with certain conditions experience €œgood €□ and €œbad €□ days €“ depending when the discussion takes place an unrealistically good or bad impression might be gained by the assessor.</p>

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	<p>There certainly are situations where it would be inappropriate to require a face-to-face meeting with an assessor. In my case it would be inappropriate to expect me to attend an assessment in a large crowded place in the winter months. I would undoubtedly end up with a chest infection.</p>
ONLINE398	<p>1) In a nut shell, everything I do with my disabled father takes longer to plan and do, requires special arrangements, is more stressful and often the help of another family member and costs more.</p> <p>It's often very difficult to predict what he can do with any accuracy because he has several disabilities and the interaction can be unpredictable. Also, although he has very long term health problems, his health is continuing to deteriorate and he has good or bad days. He isn't always able to give me clear information about his disabilities because of mental coherence issues.</p> <p>Things which can be done on good days and postponed on bad days are easier than less flexible commitments.</p>
ONLINE399	<p>1) The most obvious problem that disabled people face is that of societal values. We worship the young, beautiful and healthy. The perception of most individuals is that the disabled are a burden on society, and don't try. This has been compounded by recent government rhetoric. Small businesses are less likely to employ someone who may be less attractive, much less require some flexibility in working conditions. That's if they get as far as the interview. This has been further exacerbated by raft of government legislation which make it difficult for a small business to do anything but behave as small administrative tax gathering centres for central government. The mere thought of having to accommodate someone with additional needs is enough to put employers off, there is simply too much to have to know, learn and put in place. Why do this when there are able bodied queuing up at the door for work?</p> <p>The disabled are also perceived as being unreliable. This is because employers appear to be more aware of what disabled people have to deal with, not just varying days of physical difficulties, but mental problems too. Perhaps the powers that be might recognise this fact, since the disabled community and employers know it exists. There are good days and bad days when you are disabled, and they can't be scheduled in.</p> <p>As for evidence to support my statements. I was a manager of a small business - over 10 years ago. My director was adamant that we not employ any disabled people whatsoever. His reasons were that we were not wheelchair accessible, and a host of other, non rational explanations. He just didn't want to. There was too much work to help them do their job, too much legislation if you employed them and didn't give them what they needed. This was particularly relevant then and now. Employers are in a bad position. If they employ someone in good faith, but are not competent or unwilling to put in place what a disabled person might need, then they face legislation that says they should have. This perception still exists. The potential pitfalls are further compounded by increasing health and safety. This increases the probability of problems if employing a disabled person. This, while largely perception, is a major problem not just in employment. There are now so many rules these days, people are either avoiding situations where compliance is an unknown necessity, or submitting to control freaks who sound as though they know the law. I employed a disabled person over the objections of my director. They played the disabled card all the way. There were real and serious issues regarding their self esteem, and the social interaction between them and other staff. It didn't work out. I fired them, in the end. They knew perfectly well it wasn't because they were disabled, but threatened me nevertheless with a tribunal.</p> <p>None of the issues employing disabled people that I came across were 'real', just perceptual. The problem is social, not physical or mental. It is not the fault of the disabled for not finding work.</p>

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	<p>Since I am on a carers benefit, and unable to subscribe to information hubs, I am unable to refer to papers backing up my assertions regarding those most attractive securing employment etc.</p> <p>There is one thing I think it is essential to point out. My husband was made redundant a few years ago for the second time. His self esteem was in tatters. He is well qualified and very good at what he does, but there was no work out there for him at that time. He sent off hundreds of CV s. He only got the job he has now, because they offered a phone interview, but he paid for the fare and the hotel for the night out of our own money. His being unemployed was certainly not from lack of effort, or ability. I watched my husband, an able, clever and qualified man reduced to the point I could see he was considering suicide.</p> <p>So where does that leave disabled people, already suffering from low self esteem - which current government rhetoric and policy is in the process of reinforcing. How many refusals will the DWP deem acceptable on an annual basis? Have they established a formula for how many are acceptable before suicide becomes an option? If the DWP and government think that is over dramatic, then they need to be more proactive in actually finding out what is going on.</p> <p>I was at a Carer's forum recently. The chair herself was saying that DLA could lose the 25% who shouldn't be claiming. She is a parent carer, able bodied and with a successful career, with a healthy income. I might be one of those 25%. My son doesn't quite tick the boxes the DLA form has. They don't really quite cover what extra expenses I face as a result of his disabilities. E.g. There is no question to respond to that would highlight the laundry bill, the amount of clothing I have to buy him.</p> <p>Disability is a social issue, not a financial one. The current approach by government is a problem, compounding a barrier that prevents disabled people participating in society and leading independent, full and active lives. That is of perception, and value.</p> <p>In treating the disabled as a group in this way, they are themselves being prejudiced, and the rest of the population is following suit.</p> <p>PS, this is the name that I use for public forums, I am not about to submit my real name online. This does not invalidate my opinions - unless of course, they are unwelcome.</p> <p>5) This question is disingenuous. Since every individual responds to injury or disease in a different way, it is their needs which require a response, not a diagnosis. Therefore any response to this question can only justify interrogation and judgement of the disabled when they claim.</p> <p>It is a pity that those really less able - through not understanding the system, or intelligent enough to even understand the questions, their rights, or what someone is asking them, are going to fare badly, again with this.</p> <p>As for the medical practitioners assessing those with DLA claims, there are wildly differing assessments given by these people. How are they going to interpret the DLA questions, are they going to be subjected to rigorous methodology testing as research should be? Will they be trained, and are we going to have a democratic transparency to find out what that training is, who they are accountable to, and how their performance is measured?</p>
ONLINE400	<p>1) I would like to submit my response on the barriers that deaf children and their families face.</p> <p>By far the main problem centres on communication and in particular full access to English (or the language of the home), the language of the family, education, literacy, community and employment.</p> <p>What s the problem?</p> <p>90% of the 840 babies born deaf each year have hearing parents, who often feel seriously disempowered as they become aware that, until they can communicate fully with their child, their role as a parent is going to be very much harder than they expected.</p> <p>The reality is harsh; the longer you are unable to communicate fully and freely, the more chance your child has of being one of the 81% of deaf children needlessly isolated at home (1) or the 67% being neglected at school and having no friends (2). Your child will be a staggering 300% more likely to be two or more years behind the expected level for English at eleven years old (3). At sixteen the majority of deaf children have a reading age of an average nine year old (4). An adult with low literacy is less likely to be in good health, in work, in a stable relationship, skilled, or taking part in community life.(5)</p> <p>Current strategies to communicate with deaf babies are usually that either the whole family should learn a new language €" British Sign Language (BSL) - which takes years and is a</p>

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	<p>completely different language from English - or that families rely on hearing aids or cochlear implants to entirely solve the problem. However there is clear evidence from research which shows that not one of these on their own is working for the majority of deaf children.</p> <p>What is the solution?</p> <p>What deaf children need is a good understanding of the language of the home and education in order to achieve their potential. They can get this if their families and teachers clarify spoken language with Cued Speech. It's a simple technique using eight hand shapes in four positions around the mouth synchronised with the lip-patterns of normal speech. In this way every sound and word of spoken language can be clearly seen. It is also an extremely cost-effective solution because it only takes about 20 hours to learn the basics. Then parents can use Cued Speech to supply the clear, fluent model of accessible language that deaf children need to absorb, process and acquire the whole language of the home (6). A recent study of deaf adults brought up with Cued Speech found a high level of self-esteem and self-confidence, which they credited to their parents use of Cued Speech. The vast majority in the study felt they were always included in family conversations and activities when they were growing up (7).</p> <p>Cued Speech is also used very successfully at school to give deaf children, from both hearing and deaf families, access to English. Research shows that deaf children who have had consistent access to Cued Speech have literacy levels which equal those of hearing children (8) and they can learn to read using the same phonetic techniques as hearing children (9). Cued Speech used with hearing aids or cochlear implants is a powerfully effective combination and it can be very successfully used alongside Sign Language to give bilingualism in Sign and English. A growing body of international research and widespread use in countries such as France and the USA proves the effectiveness of Cued Speech. More background information and research references can be found from the website <a href="http://www.cuedspeech.co.uk">www.cuedspeech.co.uk</a>, or from the Cued Speech Office in Devon. With Cued Speech as the key to clear and easy communication, children can reach their potential and parents can concentrate on the job of being parents.</p> <p>2) The non-means test aspect should stay the same. Once a child has been diagnosed with a severe hearing loss, that's it. The hearing is never coming back. However there could be a way to monitor how the money is spent (learning communication techniques, social event fees, communication support fees etc..)</p> <p>3) The main extra costs for families are around communication support and access to education, information and social events.</p> <p>If you continue to solely direct families down a sign language route - rather than a bilingual approach of BSL and Cued English - then you are continuing the spiral of dependency on translation from one language to another which means permanent use of a translator leading to fees of hundreds of pounds a day.</p> <p>This consultation shows that the coalition is truly committed to independence of disabled people, so I would suggest that Cued Speech training for Teachers of the Deaf, Speech and Language Therapists, Communication Support Workers and Teaching Assistants would be an obvious place to start in reducing costs and dependency on the state.</p> <p>At present if the family of a deaf child wants to start learning sign language it will cost an average £600 per person for 65 hours of teaching to reach a very basic level (spelling, colours, objects, etc..). This is a huge cost for the family and effectively excludes the larger family circle and friends.</p> <p>Accessible formatted English through Cued Speech costs less than £400 per person and takes just 20 hours. It is not a language, it is clarity of the spoken word leading to savings throughout that person's life.</p> <p>5) I absolutely believe that an automatic entitlement to the benefit is the best solution for deaf children and their families.</p> <p>This is because a severe or profound hearing loss is permanent and costs are throughout the person's lifetime.</p> <p>A deaf person is two and a half times more likely to be unemployed than a hearing person and because of communication problems, employers are reluctant or unable to employ a deaf person.</p> <p>However if there was a generation of young deaf people with full access to English and employers who can use English directly with them, then we could expect to see the employment prospects rise.</p> <p>5) The key differences to take into account are:</p>

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	<p>- Informed parental choice. Many parents are fully informed of the choices they have for their child because the professionals aren't always looking for new solutions.</p> <p>- Continuity of communication support throughout the child's education. Due to the expense and time needed to attain a level of interpretation from English - BSL, very few deaf children have continuous level appropriate support throughout their education. A Cued speech Transliterator however, uses the sounds of English, so no specialist vocabulary is needed. In this way the Government is leading a vastly improved but cheaper to implement system, delivering better outcomes for deaf children.</p> <p>9) It is expensive, time consuming and impractical for front line staff to learn enough BSL to communicate with deaf signers who need information on benefits. In this case, the deaf person who has to bring a translator - if one is available. However, with just 20 hours of training, any member of staff could communicate freely and clearly with a deaf person in English with the help of Cued Speech.</p> <p>10) The proposals offer a new possibilities while looking to improve outcomes and save on wasteful practices.</p> <p>Unfortunately many parents do not choose Cued Speech for communicating with their deaf child simply because they don t even know about it or they don t know how effective it is. There is also a longstanding view, held by many professionals, that deaf students are innately incapable of acquiring a full understanding of English €“ which means they are not looking for ways to make this possible. Too many deaf children are being failed by the current system and we must act to challenge the system by proving to their parents and the professionals who work with them that Cued Speech really can transform the lives of deaf children.</p> <p>There is ample research evidence to counter the widely-held expectations of low achievement for deaf children. This research proves that Cued Speech can enable deaf children to achieve the same literacy levels, academic achievement and integration into the family and society as hearing children.</p> <p>A simple 3-year project to multiply the successes that already seen so that every deaf child in the UK has the opportunity to benefit from English, the language of the home and education is now a possibility.</p>
ONLINE401	<p>1) blue badge, railcard, cheaper bus tavel, cocessions at cinema, football matchs etc. encourage other organisations to help disabled</p> <p>1) discrimination by bank and building societies when trying to get loans or mortgages. misconceptions people have about disabled. anomalies between finances when claiming income support to tax credits, you can actually end up with less money taking job to claiming income support because dla is counted as income so you get less tax credits and pay more tax so you can be worse off in work. disabled family members incomes are counted as the disabled persons so there benefits are reduced.the family members is working but they are nobetter off.If a disabled person has a foreign partner they may end up financially worse off and have to support two or morepeople on less money as the partner may not be able to work until they wre married or eligiable ofr benefits.</p> <p>1) I was treated uneqally when enquiring about a loan, and mortgage because i was disabled. althoughi met their financial criteria they decided that disability befit was not a proper income.</p> <p>2) if DLA is not means tested when claiming income support then it should not bemeans tested when claiming tax credits as currently happens. ther is a silly rule currently that was devised in the 1970's whereanyone who works part-time under 16 hours is only allowed to keep £20.with the minimum wage this is a nonsense it should be £90 -100 as therwas a suggestion of raising the minimum wage to £7per hour</p> <p>?) my weekly budget would increase significantly..</p> <p>3) disabled people may use more fuel, they have to use publice transport or taxi's as they may not drive, and they don't have the money to buy cars. they have to go to hospital more often than most pople and need medication. they also may need modifications to their homes or help</p> <p>3) household, transport, medical, education, food and entertainment.</p> <p>?) personal details and disability</p> <p>4) it will depend on how they are structured. there are currently differnet rates of DLA for different disabled people</p> <p>5) yes I think people with epilepsy, mental health, blind or wheelchair bound peole should be automaticaially as they are put at a disadvantage when looking for work.</p> <p>6) I think you have to look at individuals on a personal basis to make sure that you fit the</p>

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	<p>needs to that person.</p> <p>7) I think there needs to be a regular review to take account of the rate of minimum wage and living costs etc. I am currently living alone, but I have a partner who lives abroad. It is an anomaly, but I have been told that if she came to live with me full-time I could lose £53.65 as I would no longer be a single person, but I would have to support her on less money as she would not be entitled to benefits as she is not an EU citizen. I find this very unfair, as being disabled I am already at a disadvantage finding work. If she was an EU citizen my money would go up by £30 per week. I don't understand why disabled people are grouped in with this public funds class. Get rid of this £20 rule. Don't stop family members from working carers allowance is not a great sum of money, and separate the disabled from the others claiming benefits they are special cases. Also why do you stop disabled from having savings they need all the income they can get.</p> <p>8) Yes certainly it should take account of aids such as wheelchairs. I have to have special shoe adaptations because I have a shortening in my right leg. Also I have a walking stick.</p> <p>9) Don't ask people disabled people to write things that you already know it should be simple to use, and you should be able to miss out questions that don't apply to you or you have stated in a previous form. Like do we need to fill in our address if it hasn't changed from the previous application</p> <p>10) medical professionals, disabled organisations like the epilepsy society</p> <p>11) none that I can think of</p> <p>12) personally I find re-interviews irritating as I have a condition that is never going to change much.</p> <p>13) catch the fraudsters</p> <p>14) if there was something that could help improve their lives like mobility or home insulation then they should be told</p> <p>15) sending out leaflets like junk mail</p> <p>16) I personally get an allowance of two adaptations per year</p>
ONLINE402	<p>1) for some disabled people physical problems as well as unseen problems like, tiredness and fatigue, seriously affect their ability to do anything a healthy person would take for granted.</p> <p>as with MS (which I suffer from) it's not that you have some good days and some bad ones, it can change from hour to hour or even less.</p> <p>even heat can cause an increase in fatigue, I personally hate the summer because I have very little or no energy to do anything.</p> <p>it is problems like that it is hard to make others understand, but it is a genuine problem.</p> <p>you can't plan for anything at all, you are fine 1 minute start trying to do something, so that you are not totally dependent on others, and are totally wiped out the next and there is, nothing you can do about it.</p> <p>it is really frustrating, other people look at you, and think what's wrong with them, they were OK a minute ago wheeling the chair on their own now they are being pushed, they must be faking but you're not.</p> <p>it is these unforeseen symptoms that, just can't be explained easily or planned for me like myself I used to work 40 hours a week for 23 years and do a lot of cycling, in the evenings, I considered myself a fit and healthy person, until this illness, now I as a disabled person find basic life is very hard to deal with, and it is the same with a lot of other disabled people, it's not just what you can see.</p> <p>a lot of it is what you can't and I can't see how a check done by a medical board, that lasts half an hour can make a decision on something that can completely alter someone's life.</p> <p>myself like a lot of other disabled people try to be as active as possible, I didn't give up my job as I liked working I was finished as it was too dangerous, for me to continue, not my decision and most disabled people are the same, we don't like not being able to work, and go and do the things, able-bodied people take for granted, for genuinely disabled people we would rather not claim benefits, and be able to lead normal lives but we can't, it is not the</p>

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	<p>way we would like to live or lives.</p> <p>but have no other option even going shopping,has to be planned,for someone to be with you,to push the wheel chair ect,it,s not a nice way to be but for most we didnt have a choise</p> <p>2) it takes a lot too get dla in first place only people,with genuine problems,qualify anyway as long as the checks are made correctly i don,t see why it needs changeing ,even when on dla,its not like claiments have a champaine life style so don,t change it at all,just root out those who are,coning the system,and save money that way.</p> <p>you minesters should ,have no money or assets ,and live for a year or two on these benifits and see what it,s like,it,s not easy .</p> <p>if you change the ammonts ect,you will have disabled people ,losseing ther homes ect,and that will be discrimantion,just beacause one persons illness isent as bad as another,if they are to ill to work or can,t find a job that is suietable or have adaptaionns made ect plus of corse there the health and safty laws to be considerd.</p> <p>so leave dla alone these proposed changes have been rushed through to save money beacause this goverment see,s disabled people as an easy traget ,as they are not in a position to fight back,mess with peoples lives like you are going to,and i can,t see either the lib dems or the conservetives ever getting these peoples votes again.</p> <p>2) when someone has a chronic illness,they should not ,have to have checks by the independent health speacilist,you should go on the consultants and doctors recomendations ,the same as claiming dla it goes on medical reports from consultants and speacilists,whitch is fair and correct,as these health speacilists only see the patint for a short time,when the consultant or doctor,s are better qualfyed on decisions about there condition as they see, them regualy to know weather there has been any worsening or improvement in their condition.</p> <p>(are these health care profesonals qualfyed speacilist in what ever condition each individual has or if not that is a major problem right there as they will not be qualified to make a decsition)</p> <p>the amount paid through the new benefit instead of dla should at least be the same as,dla for disabled people who have chronic conditions,that are not expected to improve as they rely on haveing a certain amount of money regulary to pay bill,s ect.</p> <p>3) a lot of people who are disabled,rely soely on benifits ,unable to walk much if at all nevermind work .</p> <p>so everything needs to be paid for through benifits,running a car if still able to drive ,mine in particular (i had to buy an automatic ,then had to have it adapted with hand controls and i had to pick a car that had a high seating position so i could get in and out easerly so it is bigger than cars i,ve had before so the fuel costs are higher tyres are more expensive ect)if i have to travel any distance for appointments and there is no family memeber to drive me then i have to ask friends as i only drive locally then i feel obligaited to give them money for doing so.</p> <p>personl items ,spray,s skin care,items as mostly sitting,or in bed ,home care items grabers things like that ,clothing for a lot of different reasons disabled people go through a lot of clothes,help with the garden ,if no member of my family is able to do then i have to pay to get it done, same with getting things fixed,or improved around the home have to get some one to do it,it is a lot of bits and bobs that just sap the money when you live on benifits you are not living in the lap of luxury,but it is nice to have a resonable existance beacause when you are disabled thats all you do is exist if you didn,t have a reasonable quality of life then life it,self would be pointless</p> <p>3) the extra cost,s disabled people face.</p> <p>that very question is unfair,for most disabled pepole,need extra money just to live,on it is a lifeline you ,may need to buy clothing on a regular bases (disabled people go through a lot of clothes due to falls,conntinence problems,we tend to drop a lot of food ect),also we do</p>

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	<p>tend to brake a lot of house hold item,s which then have to be replaced (ie when you can haedly walk but still try to you knock a lot of items over,in the kitchen ect if your gripe is poor things tend to get smashed or brocken ect),adaption ,to the home,transport,it is bad enough to live with a disabilaty in the first ,place you try it on just the benifits,if a claiment has thousands in the bank ,off on holiday reguarly then you need to look,at their circumstances,but for most these payments,go just to live</p> <p>4) the problems with two rates of care is working out if quailfy for either ,the benifits system is complacated ,and the forms long and confussing (if someone has neurological problems,or visual impairment(not nessasarily blindness)then they might not understand which to claim</p> <p>5) yes some conditions should be automatic,if the condition is incurable,and unlikely to improve and only expected to get worse,or if the patient,is serveryly disabled,or if there has been a noted downturn in the condition but the info should,be obtained from the speacialists dealing with each case as each case is individual</p> <p>6) most people who can,t do things themsleves still wan,t to feel usefull in life ,so even if they have to have help to wash and dress and get ready i think it is important,that if possable they go out,even if it is just to the shops,ect.</p> <p>even if they have to be pushed in a ,wheelchair by there carea ,or out in an adapted car,if possible.</p> <p>for quality of life rather than being left in the house,so that they,still feel part of society ,but caras and adapted cars are not cheap so it still comes down to money</p> <p>6) with some condistions evry task ,can be difficult it does vary,you have remember it is quality of life as well,if i put able wash dress and feed oneself and that was the criteria and thats all that was able to be done by onself then what would be the point in living you would be better off dead.</p> <p>if someone is genuenly living with a disabilaty ,personaly i want to see them doing,as much as they can,regardless how hard they have to try ,so i don,t think you can prioritise ,i don,t want someone saying or i saw them do this so you can cut there money down once again the only one,s who are qualified to make a decision on anybodys abilys is the medical proffesonals who see that person regularly,as far as i am concernd the more each person can squeez out of each day the better so every activity beacomes essential for everday life youve goto try and do more than just exist.</p> <p>7) it is very diffeicult with fluctuating conditions,most people try to lead active lives so if they are haveing a good day ,then they have to make the most of it.</p> <p>with a fluctuating ,illness they should get the same as they wuold for the type of disabilaty they have,as when they have a bad day .</p> <p>any good days are a bonus ,and can,t be planned for with my own condition which is m.s some days i can move better than others but ,it is rare and i never know when i am going to have a good day,and if i try to do to much it wears me out for day,s.</p> <p>so how are people going to plan for that as we don,t know ourselves ,whats going to happen .</p> <p>even when i was still able to work,the fategue would hit you and there was nothing you could do about it and fategue is a geniune symptom and is very disableing ,and affects people with m.s and some other conditions and you get no warning at all and it is like someone switches you off.</p> <p>symptoms like that can not be ignord.</p> <p>i think all that can be done for flucturating conditions is to pay them the benifits for an illness ,as if it was constant,beacause it is not somthing that can be diagosed or arranged for as with my condition good or even better days are very rare they are normaly all bad and it,s the same for lots of other disabled people.</p> <p>we are not ill beacause we want free money,i loved my job and hated it when i couldn,t do it any more.</p> <p>8) adaptions that are made are essential ,it doesn,t make them less disabled . just beacause someone usess a wheel chair doesn,t make them abled bodied.</p>

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	<p>if someone is suffering with being disabled ,just because ,they have crutches/walking frame/wheelchair it helps to use these,things but the effort required to use these is immense you can get extremely tired very quickly,leaving you very tired ,these items help but don't fix the problems</p> <p>9) the forms are way to, long and they takes days to fill in and often had to phone up for advice,i.e my m.s nurse social worker ect which is not a good use of their time. they do tend to confuse people,a simple form,and info from the consultants ,and doctors would be simpler</p> <p>10) the only people able to give a clear assessment are the medical ,professionals that are dealing with ,each case in my case,a consultant neurologist ,physiotherapist,m.s nurse,ect.</p> <p>they are the people best placed to give,the info the specialists with years of training,i don't think,a medical board is best placed,to make this assessment but that's my opinion .</p> <p>11) are these health care professionals going to be qualified to make decisions ,on complex conditions.</p> <p>i can't see how a face to face meeting is going to,be of much help you are still going to get a more accurate picture on what each case involves by having each, person's medical records checked,and reports off,consultants/doctors if some one isn't genuine they will put on a show at the meeting .</p> <p>and someone who is genuine might ,be not doing too bad on the day of the meeting.</p> <p>i don't think this is a fair way to do it,you either need access to medical history,test results,or medical reports off doctors/consultants.</p> <p>the only time i would consider it inappropriate to have a meeting is when someone is quite ill ,as they won't want to be pulled about.</p> <p>personally i think this entire benefits review is going to cause a lot of problems,as it is impossible to know what someone has to live with and decide if they are fit for work in a meeting ,i had a job which i loved doing and did so for 23years but started to fall a lot i tried to carry on even going part time ,to keep it health and safety was the reason i was finished off ,so if in this face to face meeting it is decided that ,an individual is fit for work ,then finds a job and then has a serious accident related,to the reason that they were classed as disabled in first place,then the government ,or this medical board would be liable</p> <p>12) once again unless the ones carrying out the reviews are qualified in the particular ailment that each person has then i can't see how these reviews can be carried out.</p> <p>once again it should only go doctors,and consultants notes ect .</p> <p>consultants train for years to get their qualifications ,i can't see how it would be fair for someone who hasn't got the appropriate qualification and all the case notes to make a fair decision.</p> <p>yes type of review should depend on the nature of disability and be carried out by the appropriately qualified doctor or consultant other wise it is not fair and properly not legal (a heart specialist is not going to be qualified to deal with a brain problem or joint problem liver problems arthritis ect ect ect)now is your average gp</p> <p>13) i am not sure what to answer to that,you can't get people to more honest if it means that they would be worse off.</p> <p>i think you will still have to rely on the periodic appointments and the undercover fraud teams already used there is no easy answer to that one</p> <p>?) a lot of the disability charities think this review is a waste of time and government is going to push ahead with this regardless.</p> <p>if this is just a way to get genuinely ill people off benefits and the disabled is just seen,an easy target then ,myself and just about all disabled people will be very disappointed.</p>

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	<p>personaly i dont think any of this will work ,and the government will in the end be worse off not better ,as i can foresee breaches being made in the human rights and disabilaty legletration and claims for personal injuy if someone is classed fit for work and has to get out to work against doctors advice,if they are injured or it makes what ever ailment they had worse ,i think you are opening up a whole can of worms and once up and running will turn bad very quickly thats my opinion ?) clear instructions to what they can claim and how to go about,it.</p> <p>so far all the forms i have filled,in are to long and compleacated.</p> <p>it would be even easyser if a claiment could see a benefit ,adviser take there finacial ,details,details of there condition,contact details for consultants/doctors ect ,along and have help to fill in the forms,it also will give another oportunety to asses,if a claim is genuine,or not if someone is to ill to travel,it might be an idea,to have home visit,s .</p> <p>this idea might help to cut fraudulent claim,s ,as an individual ,could be assed the same time. ?) dla is very important,as a lot of other services and entitlements,use this as proof of disabilaty, as it is not easy to claim,the forms are extensive,to fill in and you have supply,personal info on how your condition effects you,so other services use this,proof of your illness,(whitch i think is a good thing as it has helped, me to acsess services and benafits i need)but some of these might not,be available to none claiments,but help them.</p> <p>you should make other services and benafits,take each indevidule case into ,acount on there own merits,yes still allow dla to be tacken into acount ,but also non dla claiments, should get the help they need on the merits of ,there own case.</p> <p>that,s why i personly think ,all claiment,s dla or otherwise should see a benafits adviser,who can advise on what can be claimed,and help them fill in the forms and submite the claim,or you could have a department,of qualified personel,that could either vist ,at home,or have to go to,at an appiontment to do it all and the claim gets done,on site there and then as long as all relevent info is available.</p> <p>now that would be easier more cost effective,and safer. ?) it is hard to see for the current dla forms,disscriminate,i have filled them in myself and don,t see any discrimanations.</p> <p>i belive yes certain conditions should still have the automatic inclusion,if they have an incurrable condition,a degenrative condition,or a condition that there is only symptomatic treatment and no treatment,for a certain condetion,especially if there is not expected to be,much if any improvement.</p> <p>it is important when developing a policy like this,that you take as much into consideration as possable ,and youve also got to remember you are looking ,the money disabled people relay on to live on,and the cost of living is riseing dramaticly,at the moment,and is set to get a lot worse.</p> <p>and it,s not much good saying that the goverments stance is to aid a return to work,for a disabled person it also it slso,has to be suiteable work i,e disabled tiolets,fire exsits that are wheelchair frendly in an emergacy,no stairs ect,and it is amazing how meney premisses still arn,t disabled frendly,spend a full week in a wheelchair and find out.</p> <p>and there are other considerations,i can,t see how you could delelope such a policy.</p> <p>it is very diffeicult,i honestly think the best way forward ,is to put everyone claiming dla on the replacemant,on at least the same money they allready get,properly vet new claiments,then start reevaluating the current claiments,the problem is peole get used to haveing it,and don,t tell anyone that there condition has improved,i would love my illness to be cured,then i could get my life back,but untill then i am stuck on benifits.</p>

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	<p>but even then would you be well enough after years being ill to straight back to work? doubtfull .</p> <p>this new policy has a hell of a lot to consider,it is not going to be easy,thats why i think,it is very impotant to make it easyer claim and as much care as possable be taken to stop the fraudenlt claims,but make sure it goes those who need it ,there are bound to be,some who do need it,get left out and there will be complaints and problems. ?) it would make a drastic difference as it would make,claiming other benefits easier if, a shared dater base,of claiments could be kept.</p> <p>thats why i think a central,department for benefits should be sat up,it would centralize the system of benefits,and make it easier to check for fraudsters.</p> <p>the idea i have is.</p> <ol style="list-style-type: none"> <li>1, someone is told that they have a disabilaty/or illness</li> <li>2, they are advised to stop working/or reduce hours(if relivent as they might not be in work or to ill to ever have worked)</li> <li>3, they have to have an assesment, which includes giving details of doctors/specialists/physiopherapist,our relevent health professional ect for the diagnose to be confirmed,</li> <li>4, the doctors/speacialists/physio ect who ever is relavent,can then send a letter,conferring there recomendations,and how the illness,or disabilaty is likely to affect the individual,and whever the condition is likely to improve,stay the same,get worse,or they don,t know,and will need regular check ups.</li> <li>5,an appointment to work out what benefits should,be awarded,and all the forms,filled out there and then (as long as all the relevent data is available, if it is not a reduced rate should be paid untill it is available).</li> <li>6,all the benefits (i,e dla (or it,s replacement) houseing benefit,counsel tax reduction,blue badage ,nhs card for dental/glasses ect,should all be sorted out,what they can claim/should claim ,should all be sorted out there and then.</li> </ol> <p>by setting it up this way the claiment is advised,and helped to sort it all out,the government has got records of what,s going where and why,and the doctors/consultants ect must be made to inform you ,of any change in condition,ie better or worse ,people with chronic condistions or disabilaty would ,be able to inform directly of change in condition themselves,but all claiments should be assigned a social worker who has to do a review of each case every 6 to 12 months to keep track, if benefits claimed ,still meet the needs of the claiment and report any changes. then changes can be made acordenley . if a claiment is unable to go to these benefit appointments, then arrangements should be able,to sort this out at the claiments address. i think centralising all the benefits and service,s is the only way to simplefiy the system cut out the bureaucracy and make sure the people who needed it get the help needed,to have as easy ,and active life as possable ,plus centralizeing the system should,make it easier to find fraudulent claim,s as all the data will be available to investergators in one place. i personaly have not met anyone who is disabled who have found ,claiming benefits easy. ?) it would make thigs a lot harder,it is stressful enough,living with a long term,disability or (so far incurable)illness ,whithout having to worry,how to pay,for every thing. a lot of the benafits and services dla allows access to,are as essential, as dla it,s self . it,s only the cheat,s that end up with ,lot,s of money left over,and go away on holiday,regularly and have a lifestyle,that is lavish for the rest of us,it,s are only income,and needed to live ,so losing other benafits that dla gives you access to will make,an allready hard life,worse. ?) no a lot of adaptions are done by local counsels,and through ,help by the nhs ,to get them done,but they don,t cover everything. ?) when assesing childeren the help and benifits need to grow with them,they are the future,just beacause they are disabled,does,nt mean they won,t be brillent and contrabute a lot in there lives.</p> <p>but it has to be taken into,account that they are growing physecaly, as well so they will</p>

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	<p>need more money and support as they grow.</p> <p>no one knows who is to say that a disabled child,wont beacome a great scientist, or a teacher or a doctor ,children are the future of evertthing,that exists,eventually they will be everything,us adults,are now so disabled or not we have to give them every chance.</p> <p>but with a disabled child,both them and there parents need all the help that can be given.</p> <p>childeren will beacome tenagers ,then adutls,you have to take clothing,adaptions ect into account adaptions that might have been ok ,when they were smaller,won,t be any good as they get bigger the best people ,to asses there changeing needs,are the parent,s or careras that are there while they are growing ,so need finance ie benefats to match.</p> <p>?) yes as i said answering the previous question,it would make it easier,and also give another chance check,the vadility of a claim ,i think if you had to see,someone for advice and help before,you could make a claim,would also deter fraudsters.</p> <p>as well as make it easier for geniune claims to be made,and also make sure ,people are getting the right benefit for there needs.</p> <p>but with a disabled child,both them and there parents need all the help that can be given.</p> <p>childeren will beacome tenagers ,then adutls,you have to take clothing,adaptions ect into account adaptions that might have been ok ,when they were smaller,won,t be any good as they get bigger the best people ,to asses there changeing needs,are the parent,s or careras that are there while they are growing ,so need finance ie benefats to match.when assesing childeren the help and benefats need to grow with them,they are the future,just beacause they are disabled,does,nt mean they won,t be brillent and contrabute a lot in there lives.</p> <p>but it has to be taken into,account that they are growing physecaly, as well so they will need more money and support as they grow.</p> <p>no one knows who is to say that a disabled child,wont beacome a great scientist, or a teacher or a doctor ,children are the future of evertthing,that exists,eventually they will be everything,us adults,are now so disabled or not we have to give them every chance.</p> <p>but with a disabled child,both them and there parents need all the help that can be given.</p> <p>childeren will beacome tenagers ,then adutls,you have to take clothing,adaptions ect into account adaptions that might have been ok ,when they were smaller,won,t be any good as they get bigger the best people ,to asses there changeing needs,are the parent,s or careras that are there while they are growing ,so need finance ie benefats to match.but since a lot of conditions get worse over time,a one off payment ,wouldn,t be sufficeint,as peoples conditions change,there needs and help,inc adaptions change ,with my own condition ,i never had to have a wheel chair before but now i,have had to ,i have had to have more handrails in stalled,as things change adaptions,and things needed to help change.</p> <p>it,s not much good having a,one off payment,if in six months time,you find you find you can,t get ,in and out of the bath anymore,and have to have a walk in shower/or wet room built.</p> <p>because you would have find the funding for things like that,it needs to fluent as the needs of the individul change it needs too.</p>
ONLINE403	<p>?) Data should be collected to ensure that the equality element is addressed</p> <p>1) DDA Compliance on Transport, local facilities, shops, public buildings, pubs restaurants etc are in need of enforcement. Society needs education on the needs of disabled people. Disabled parents with children need support for both</p> <p>1) I am a paraplegic an despite the DDA, access to services, buildings etc has not been enforced and most of what I, my wife and son (who are also disabled) are restricted in taking a full and active role in society let alone independent. I do try, in some way, to repay</p>

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	<p>the support I receive by volunteering as a school governor, JP and Chair a national Childrens Charity who all make allowances for my support needs</p> <p>1) There does not seem to be a joined up service between the benefits and providers and the availability is very hit and miss depending on location. Enforcement of the DDA would assist</p> <p>2) Conditions that have been recognised in law as dibilitating and requiring support as evidenced and recognised by the DWP, Attendance allowance unit</p> <p>Adults with Learning Disabilities should be supported in the completion of any (all) forms, assessments and interviews</p> <p>2) If you have a recognised disability that has been identified in case law that support with living and mobility issues has been recognised then support and benefit should be virtually automatic</p> <p>2) My only issue with this is that the service has to be locally available and with the CSR many local support services have cut back or closed down</p> <p>3) Extra care for home tasks, (washing, dressing, cooking cleaning etc) Shopping - assist with Children and siblings to try and ensure some qualitative family life. Household and gardening maintenance tasks - Try to have a social life, albeit limited to help feel part of the community</p> <p>3) Heating, personal support for care, shopping, gardening, household maintenance. Transport. Support for Child carers. Suitable equipment</p> <p>5) It has always been an issue that certain disabilities have a wide range of severity but equally carry no cure and can be severely dibilitating one day and not so bad the next. Regular assessments or checks with GP should assist with this</p> <p>6) By consulting the individual and those that know them best, i.e. Partner/Spouse/Parent, GP, Social Worker etc., and work out a care plan suitable for life (with annual review)to ensure that the disabled person has the best opportunity to engage in society</p> <p>6) This is very difficult and should play a minor role in this consultation - what is essential for one person (even with the same disability) may not be a priority for another Those with learning or mental health issues need extra support</p> <p>7) Annual reviews, include GP and those close to (and including) the disabled person to review any changes and changes to individual plan</p> <p>7) See answer to question 5. For me I am more than happy to be assessed every year (as I used to be) and for the various medical personnel involved with me to submit reports</p> <p>8) Certain conditions deteriorate or alter over a period of time so regular equipment assessments should take place</p> <p>8) This is an essential need and continues on with being part of a regular review - by looking at these on a regular basis it should minimise a sudden need for major adaptations</p> <p>9) Consult with user groups for varying disabilities</p> <p>9) Set out the criteria for the claim and what the qualifying elements are</p> <p>Offer support via your local offices to complete the form if possible</p> <p>10) A summary from the GP or specialist of prognosis and clear and simple requirements such as, needs assistance with wheelchair when going outside, needs monitoring regularly due to Learning Disabilities, assistance with cooking. More specific information could then be sought to clarify the specific needs</p> <p>11) This used to be done and should not cause any issues as long as the healthcare professional is suitably qualified to access specific needs of the individual. It would be essential as part of the process that the face-to-face meeting takes place in the home to ensure that the needs are seen clearly but it would also be useful if part of the process could take place outside of the home by observing how they cope with local facilities</p> <p>17) Prognosis of condition. More frequent assessments of equipment to allow for growth</p>
ONLINE404	<p>1) If the Lowest Rate children get nothing, they CANNOT have any access to participate in anything as a lot of things need to be paid for, also parents of disabled children may not go to work so how do they pay for clothing toys beddings ect?</p> <p>1) The Barriers are that Disabled people are not getting enough access to society as it is! every Disabled person and their families have a struggle to get what they want! cutting Benefits will make this far more worse!</p> <p>2) The Benefits MUST stay in 3 individual Categories, High, Medium and Low!</p> <p>3) I know that as a parent of a disabled child we did not get anything towards the Electricity and Gas this winter when tempretures were below freezing. I have to pay for my son's</p>

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	<p>Holiday club. and also weekend club that benefits his communication and health.</p> <p>4) The Benefits is already worked out in 2 components 1 is personal care and 2nd is mobility so what is there to change?</p>
ONLINE405	<p>1) I think that awarding PIP indefinitely would encourage people not to report changes. Therefore we should issue a new 'form' asking for their current circumstances about 5 years down the line. Obviously this would not be the same as the original form so that they couldn't just copy the information. Customers who are paid into a bank account should have warnings next to their payments counting down how many are left before the final payment is made encouraging them to complete the renewal form. This would stop the constant excuse that they did not receive the form because it would be in their domain and if it genuinely did not turn up they would have the information to call us and ask for one and track it.</p> <p>4) Some aids and adaptations are provided by NHS. I think giving an option for a one off payment would be easily open to abuse.</p>
ONLINE406	<p>1) Disability is very varied. Barriers are things like not being able to do things that others can do eg. personal care like washing oneself and/or domestic tasks (like making your bed, getting to places), being able to organise yourself or communicate. Other really debilitating factors are; pain, exhaustion and weakness. Costs of things like wheelchairs can be exorbitant especially if you need more than one. Disabled people who cannot work and rely on benefits are the most disadvantaged. Many employers don't know about "Access to Work" and many disabled people are excluded from the job market because they only have the resilience to work part time.</p> <p>2) The fact that you qualify should continue to entitle you to things like benefits disability premiums and the motability car scheme.</p> <p>3) The costs for disabled people are rising as more things become technically possible and expectation increases. eg. you can now get wheelchairs that can cope with rough terrain or lift you to a height of people who are standing. Many of these helpful devices greatly increase what you can do but they cost a great deal of money. The criterion for this aspect of the PIP should be whether you need an item (like a wheelchair) or help from a person to function independently.</p>
ONLINE407	<p>1) I don't know.</p> <p>?) Of some use.</p> <p>1) Stigma, harassment and other hostile attitudes.</p> <p>2) The level of financial support provided.</p> <p>3) Cannot say.</p> <p>3) The cost of overcoming the barriers caused by their disability and improving their condition.</p> <p>4) Perhaps not. Three rates might give greater flexibility.</p> <p>5) Some health conditions should mean an automatic entitlement to benefit.</p> <p>6) By fully acknowledging the effects of psychological impairment on leading a full and active life. Apart from basic physical functions, the importance of social functioning should be recognised.</p> <p>8) Unable to comment.</p> <p>9) Clear communication and simple English.</p> <p>10) Evidence from the disabled person's doctors and care workers.</p> <p>11) The DWP might put pressure on professionals to disqualify a large number of claimants. No doubt some circumstances exist where the face- to- face meeting would be undesirable.</p> <p>12) All relevant evidence/criteria might be used. There should be different types of review depending on the needs of the individual and their condition.</p> <p>13) Fair guidance.</p> <p>14) All relevant information which should be provided as part of the claiming process.</p> <p>15) Probably not.</p> <p>17) Cannot say.</p>
ONLINE408	<p>1) Fear. When you suddenly become disabled, as I did, out of the blue with myasthenia gravis, all my confidence went and I was afraid that I might collapse at any time (which I did frequently) or that if I went anywhere and started to feel weak I might be stuck there. One of the drugs i take to stimulate my muscles also stimulates the bladder and bowels and the fear and embarrassment of accidents is awful. From being a strong and confident person I became a physical and mental wreck. When a neighbour helped me apply for the</p>

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	<p>DLA it made a real difference to my life; I could only work part time and at a much reduced level so the money was a great help but having a reliable car was huge boon and greatly helped my confidence. DLA made, and makes, a huge difference to me. It enabled me to carry on working for a few more years, paying taxes and teaching our children.</p> <p>2) The DLA has meant that applying for the vital blu badge is automatic with my council so that is excellent.</p> <p>2) It would mean more forms to fill in, more letters from consultants and just more hassle which some folk may just not have the stomach for.</p> <p>3) Reliable transport. This is a vital necessity if we are to get out to work and for leisure. The Blue Badge is a Godsend.</p> <p>4) I think it is a good idea to simplify it.</p> <p>5) Yes they should. I realise you wish to save money but it is cruel to say to one person on dialysis that they can have the comfort and reassurance that the benefit brings, but not give it to another person in similar circumstances.</p> <p>6) Getting out of the house is vital so help with the cost of reliable transport is essential.</p> <p>7) You can't guarantee to do this, but it would be sensible given the money involved to ask for an annual consultant's letter. Note- not just a doctor's note.</p> <p>9) The claim form must be lengthy given that it needs to assess a person's intimate physical needs. A shortened one makes it more likely that an assessor will simply reject it. He or she must fully understand what difficulties the climant faces; this can only be done by detailed questions.</p>
ONLINE409	<p>1) Societies attitudes to the value of disabled people, more needs to be done at childhood level in schools, nurseries to include disabled people in everyday life so attitudes change. The formal education of learning disabled people is not good enough, many leave school still unable to read or write how can they participate in society without much needed basic skills. Not enough is done to support carers especially carers who also work as they cannot claim a carers benefit to support their relative and these people are vital to support disabled people lead more active lives.</p> <p>2) The level of assessment is not equitable, especially for children. Parents can misrepresent their childrens illness/disability and therefore label children through life. Also more should be done to assess why the child is disabled i.e, many parents claim for ADHD, Autism but sometimes this may be because the parent abused themselves in utero i.e. drug addiction, the benefit should be checked to see if it is being used to support the child and what is being purchased for the child rather than it just be another income for the household.</p>
ONLINE410	<p>1) For people with learning difficulties and/or autism and/or no speech, problems communicating can be a huge barrier to participation in everyday life. Having challenging behaviour (or behaviour that challenges society's "norms" but which in itself is a communication) can pose another enormous challenge. For people with learning disabilities another thing that prevents participation is simply thinking/acting a lot slower than "the norm". Everyday life happens at too fast a pace and most people are not aware to slow down enough to give a person who has learning difficulties the opportunity to participate. For people who have such needs in order for them to be able to live an independent life and participate in ordinary activities they need a high level of carer support and they also need help to keep themselves safe and to get out and about. Society needs to be more welcoming and be willing to make reasonable adaptations to enable people of all abilities to participate. There are very few opportunities for adults with such difficulties to gain employment, or to join clubs or participate in the kinds of activities that everyone else takes for granted.</p> <p>3) The costs of getting around are hugely expensive. Public transport is really not an option if you have severe learning disabilities/autism and challenging behaviour so it's essential to have a car available. Extra equipment may also be needed inside the car (such as special harnesses) to keep the person safe. For my daughter we also use the DLA money to fund specialist private speech and language therapy services as these are not otherwise available to her. We have also used the money to buy expensive communication equipment (voice output devices) and expensive computer software that offers communication support (eg for making up symbols for visual schedules). These were not offered through normal services but they are making a massive difference to her. We have also used the money to pay for a private clinical psychologist as she was able to offer strategies to help deal with the challenging behaviour. The money has also been</p>

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	<p>used to pay for training and workshops and to purchase resources that offer help in dealing with my daughter's condition. The money also goes towards paying for specialist equipment to encourage my daughter's independence in such activities as eating and bathing.</p> <p>5) I think that all claims should be based on the needs and circumstances of the individual, since there can be huge variation even amongst people with the same diagnosed condition.</p> <p>6) Prioritise support to those least able to live full and active lives by ensuring a thorough assessment of each person's needs. The assessment should be totally person-centred and should be conducted in such a way as to be accessible to the individual concerned. This may mean it is conducted at a slow pace and the person is given support to make real choices about their own lives and what is important to them. The most essential activities are keeping safe, having a means of communication, receiving the support necessary for basic life needs such as eating, drinking, sleeping and toileting. Also extremely important is the ability to engage in meaningful paid employment which offers not only an income but also a sense of self-worth. Essential too is the ability to be able to pursue interests and hobbies of one's own choosing and to be able to choose where to live, who to live with (if applicable) and to have the freedom to live a full and active life.</p> <p>7) Obviously completing a full and thorough assessment can be costly. Could you at regular intervals (maybe annually) send out a form summarising the basis upon which the benefit decision was taken and asking the person or their representative to either sign the form to say that nothing has changed, or to list any changes in condition that have taken place in the intervening period? One way to save money would be to send this out electronically to those who have e.mail facilities.</p> <p>8) The assessment should take into account communication aids. To a non-verbal person these are as essential as a wheelchair is to a person who has mobility problems. Yes the assessment should point the person in the direction to obtain any aids that would help them. These should include mobility aids and any aids to daily living that enable or encourage a greater independence or enable the person to gain access to activities that would otherwise be impossible for a person with their disability.</p> <p>9) Wherever necessary provide facilitators who can help individuals to complete the forms or complete the forms on their behalf. Make the eligibility criteria very transparent so that people will know if they are likely to qualify.</p> <p>10) I would suggest gathering evidence from a variety of professionals, who have regular contact with the disabled person. This could involve a GP or specialist consultant, a nurse, speech and language therapist, physiotherapist or occupational therapist. It needs to be a professional who has regular contact with the individual. In our experience, professionals who merely meet the person for a half-hour or one hour assessment often end up writing reports that contain a load of inaccuracies.</p> <p>11) A face-to-face meeting is fine when the disabled person is articulate and able to communicate about their condition and how it affects them. For a person with learning difficulties and/or autism this would need to be a discussion with professionals and/or carers who work with the disabled person and are very familiar with their everyday difficulties and needs.</p> <p>13) You could, at regular intervals (eg annually) send the individual (or the person acting for them) a summary of the case or criteria on which their particular award is based and ask them to confirm whether their circumstances are still the same. If not the same, then ask them to report the changes.</p>
ONLINE411	<p>1) DEPENDING ON THE DISABILITY MAJORITY REQUIRE HELP AND UNDERSTANDING.</p> <p>3) PAYMENT FOR HELP WITH PERSONAL CARE FROM SOMEONE YOU TRUST.MOBILITY NEEDS.</p> <p>5) 2 PEOPLE WITH THE SAME ILLNESS CAN BE AFFECTEDIN DIFFERENT WAYS OTHER FACTORS NEED TO BE TAKEN INTO CONSIDERATION.</p> <p>6) MAKING LIFE INTERESTING AND KEEPING PEOPLE SPIRITS UP.</p> <p>7) CUSTOMER NEEDS TO BE ASSESED MORE OFTEN</p> <p>8) THE PUBLIC NEED TO BE MADE AWARE OF WHAT HELP AND SUPPORT WITH AIDS ADAPATIONS ARE AVAILABLE</p> <p>9) MEET THE CUSTOMER FACE TO FACE VIST THOSE THAT ARE NOT ABLE TO COME INTO THE OFFICE.</p> <p>10) HOSPITAL COSULTANT</p>

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	<p>12) REVIEWED REGULARLY  13) SHORTER AWARDS GIVEN ASSESSED MORE OFTEN  14) N/A  15) DO NOT HAVE AN ANSWER  16) POSSIBLY  17) QUALITY OF LIFE FOR THE CUSTOMER AND THE EFFECTS ON THE REST OF THE FAMILY</p>
ONLINE412	<p>1) Mobility. Public transport is just not geared for mobility problems. Without my mobility car I couldn't get to work because I'd need to get two buses and stand around bus stations - something I can't do as I can't stand for any length of time, have poor balance etc.  1) Society is the main barrier to preventing disabled people participating in society. Society, and how it is structured. It is better than it was - better access to more buildings, legislation against discrimination etc. but there could be more done. I work in the public sector and that is a good employer for someone with a disability. I think the private sector avoids employing disabled people because of the cost. Public transport needs improving. If I didn't have my mobility car I would struggle. Getting around is a big problem if you have poor mobility.  ?) The main benefit to me has been my mobility car  ?) Just more problems when we have enough to cope with  2) Link it to the mobility car scheme. This is a life line to me. Gives me independence. Allows me to work. I'd have to stop working without my car.  2) The link to the car mobility scheme should stay - I think the proposal is that it will? Breaking down the benefit into getting around and things needed to take part in everyday life is a good way of breaking down the issues.  I do think that some conditions should automatically entitle you to help. I think, for example, if you have Spina Bifida you should get help. Some people with Spina Bifida may cope better than others, but that shouldn't mean that those who cope better should not get help. Unfortunately that is what the PIP seems to be aiming for. I think that is very unfair.  3) For me (spina bifida) getting around and incontinence products are two main costs. I couldn't use public transport to get to work so have a mobility car. This gives me independence. It has to be an automatic which would cost more if I had to buy on my own and I couldn't afford to. Therefore I couldn't work. I need more showers etc, so heating and water and everyday products tend to increase my basic costs.  3) I guess that depends on the condition. Most disabled people will have extra cost in adaptations from major ones to the home to needing walking sticks. Then there may be the cost of personal care and carers. Special foods, medicines. Transport can be a major cost. The list is endless! My partner works part time so that she can do the housework, shopping etc that I find difficult. It just is a fact that disabled people will face additional costs.  4) I'm not sure. More than anything we need a fair assessment. I can help but think this is a money saving exercise and that the aim is not to help but to get as many people off the benefit as possible whether they need help or not. The extra stress this whole consultation is creating to people already facing very difficult situations is terrible. It's a pity the Government couldn't spend the same time and money chasing the fat cat tax avoiders and the real cheats.  4) Not sure how you can separate the two parts. Mobility IS a key component of being able to participate in daily life. If I can get to work, shops etc then I am part of daily life. Cut that off and I'm stuck at home. You don't have to be a wheelchair user to have a mobility problem that can curtail your ability to live an independent life.  5) I think this is really unfair. I am very very independent. I carry on when a lot of other people wouldn't bother. I work full time. I walk through pain. That doesn't mean I don't need help! How are you going to assess people who "down play" their condition? I have spina bifida and tethered cord. It isn't EVER going to get better. But I think I cope better than a lot of people do. That does NOT mean I don't need help. So, yes, I think some conditions and impairments should mean automatic entitlement.  5) Yes, some health conditions and impairments should mean automatic entitlement. What worries me about the proposed PIP is the suggestion that those who cope better with a condition won't get help. That seems very unfair. Again I can't help think this is a cost cutting exercise.  6) Mobility, social interaction and being able to live as independently as possible. These are the activities which need supporting.  6) Mobility. Getting around safely and independently if possible.</p>

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	<p>7) Don't just assess the person as they are on the day of the assessment. Often people have good and bad days; days when they can walk better and further and days when they can hardly move for example.</p> <p>8) Anything a person needs to lead a full independent and active life. These are the extra costs disabled people have to cope with and help should be given.</p> <p>8) Yes, if someone needs an aid/adaptations then that has a cost. I couldn't manage without a stick, continence pads, adapted car. The DLA helps me with the cost of those needs.</p> <p>9) I don't really know! These forms are hard to fill in even for the most literate and able. It's unfair that, often, it's just the form that is used to decide who gets what. Ideally everyone would be assessed by a qualified doctor not a civil servant. But I imagine the cost of that would be prohibitive.</p> <p>9) Only medical qualified people should make the decision on awards.</p> <p>10) Assessment should be made by a qualified doctor, not by civil servants. That is the only fair way.</p> <p>10) I really can't see that you can assess from a form!</p> <p>11) Ideally all should be face-to-face.</p> <p>12) Some conditions are never going to improve, or change. These people shouldn't have reviews. It doesn't take a rocket scientist to know which conditions won't change or improve!</p> <p>13) As mentioned above. It should be easy to work out which conditions won't change and which could. The latter ones need to be reviewed. The former don't.</p> <p>14) The criteria for the award.</p>
ONLINE413	<p>1) There are two main problems stopping disabled people leading independent, full and active lives. The first is they rarely have adequate equipment to make the most of their own capabilities. The second is they frequently do not have enough assistance to enable them to function as well as they could, which should if possible be on a par with non-disabled people. For severely disabled people, equipment costs are prohibitive. People such as myself are expected to pay for their own hoists, highly adapted vehicle, electric wheelchair with specialised seating and many other things out of DLA. A limited amount of means-tested statutory help is available, depending where one lives, but DLA itself is nowhere near enough. Without these items comes dependence on other people, but there is none left to pay for those people! I realise that those with only small amounts of capital will get free basic personal care, but those severely disabled people who do not satisfy a means test are rarely prepared to spend all their family's money on care (maybe £1,000 per week), with the result that they lead restricted lives using volunteer carers. As an example of the anomalies, the level of capital allowed for means-tested help makes it impossible for anyone provided with free local authority care to save for a self-drive wheelchair accessible vehicle, since these cost more than the limit and hence, once the limit is reached, future savings must immediately all be used for care.</p> <p>2) It should be possible for those assessed as needing the maximum payments, and with conditions such as spinal cord injury that will definitely not improve, to be awarded payments for life. This will reduce administrative costs.</p> <p>3) Cost of equipment (can be huge), paying for carers (can be enormous), paying for cleaning, gardening and other household tasks (substantial), extra heating, extra electricity (charging wheelchairs, hoists etc), extra water (more shower/baths and washing because of incontinence), higher phone bills (if cannot visit somewhere in person) specialised clothing, expensive food (because may have no choice where to shop or because of an unusual diet), more than normal for holiday accommodation with appropriate facilities.</p> <p>4) Reducing the rates per component to two will not make the benefit any easier to understand, but perhaps easier to administer because an individual is less likely to move from one band to another.</p> <p>I doubt if adequate support can be given to the most severely disabled people, relative to the rest, if there are only two levels of support.</p>
ONLINE414	<p>?) Assessments proposed so far are demeaning and costly to implement. This type of assessment will unfairly prejudice the case of those with new illness such as CFS/ME. Though some who suffer from ME may recover or improve, there are those who are permanently damaged by a virus which would drastically affect daily living but sufferers would be able to turn on a tap or pick up a coin. Assessment should be by 2 NHS</p>

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	<p>consultants who confirm a medical condition.</p> <p>1) Practical support which may require training or retraining. Essential for those who are physically disabled but who have a good academic background should be allowed university education with full funding. In my experience there may be more chance of supported work if academic talents are used as physical work is not an option.</p> <p>3) Mobility and care are important factors. However, a good balanced diet is necessary also. Those who cannot afford a good balanced diet may have to do without or buy unhealthy foods because their income is so limited. Yet a woman recently in the news who can pay £600 per year on golf membership and get the benefit is unfair.</p> <p>4) Two components may be more limiting unless you broaden the scope of entry into the categories. Payments should also increase age at retirement as the state pension rises.</p> <p>8) No. The medical condition, if confirmed by two NHS consultants, should not need to be based on any equipment used. The source of equipment for individuals could be an issue. It is costly to provide equipment which is on loan from the NHS as there should be systems in place for maintenance, record keeping etc. Could this be an area for change if equipment is ordered for an individual and returned to SS or NHS or replaced as appropriate?</p> <p>9) You can simplify the form by only asking for Name, address, NHS number, NI number, medical condition and name of GP or Consultant, social worker, for example. The process may be made easier by the form being sent to approved consultants, already being paid by the NHS, for their assessment. This could eliminate the need for DWP doctors who could then be retrained medical professionals into hard pressed NHS positions.</p> <p>11) Appointment time will be important. Sufficient time to get to know the person/individual applying. If the medical professional is unfamiliar with the case it will be necessary for the applicant to have the time to put their case forward. A consultant may be required to give a medical opinion to an appeal panel.</p> <p>12) If a medical condition is confirmed a permanent there should be no need for a review. If DLA is awarded only to those with permanent disability would there be a need to review at all?</p>
ONLINE415	<p>1) Being able to get escorted transport to and from centres providing stimulating activities like singing, dancing, card games, and genral day to day activities like making lunch writing a lletter or post card filling even writing a diary so their well being can be monitored and ajusted where necessary.</p> <p>3) Paying for escorted trnsport and facilitated day care. This type of centre has been subject to closure under the cuts made by local authorities. The disabled person may need help in understanding the money is to be used for this type of activity due to the need for qualified personel to manage these events.</p> <p>4) Most events relating to helping diabled people incur expense in both the mobility and care aspect of the care required. Faciiltating care is likeley to require importing goods and services to provide the care or travelling to a place where the care can be provided. In both cases the there will be a requirement to provide sustenance</p> <p>5) An automatic entitlement would help in the inital stage when the customer has the extra costs of facilitating their disability. The initial diagnosis should trigger the application process to ensure their inital needs are met then further consideration when all aspects of the support needed is established.</p> <p>6) Notify local care support groups where DLA customers live to follow up comunity suppot where needed to check requirements i.e. shopping prescriptions and hospital appointments. Sign post on award of benefits and request reports where the system is failing.</p> <p>7) Consult with professionals as well a the customers to make sure money is invested in the right direction for the care required.</p>
ONLINE416	<p>1) The main problem for disabled people is of course their disability. If they weren't disabled they wouldn't need to rely on the rest of society as much as they do. It is good that it is now accepted that disabled people are equal and should be part of society but they still need a massive amount of support. Employers, members of the public and so on don't have the capacity in their busy lives to accomodate disabled people. That is the fact.</p> <p>3) Support costs are the highest for disabled people. They are constantly having to pay people to help them live something of a normal life. Just because a person can walk doesn't mean that they don't have mobility problems.</p>

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ONLINE417	<p>1) The simple nature of disability means that there are problems and issues which need to be overcome which in many cases costs time and money relative to non-disabled people. The investment to overcome these issues may be required by the disabled person or more widely in society.</p> <p>2) Flexibility needs to be retained, especially as needs may change in the future. One key element is that of mobility which is a fundamental part of giving a disabled person independence and self esteem. The needs in this area will alter as a person moves into adulthood and their lives develop, removing mobility support can inhibit this - especially if the person is in residential accommodation.</p> <p>3) This is impossible to answer in detail as the spread is huge and the needs often change with time. The one constant feature is the need to support overcoming whatever barrier presents itself when this happens, such as employing a carer, buying specialist equipment, etc as the person moves from childhood to adulthood at home and then into independent living. On the plus side this means that costs can be saved as well as some services are only required transiently.</p>
ONLINE418	<p>1) While the public transport is there for the deafblind people to access, which they do, the facilities that are accessible to the deafblind people are not in the local area and are very difficult to access via public transport. The DLA currently fund 2 vehicle for 6 deafblind people to access and if they no longer had these vehicles it would have a negative impact on their lives</p>
ONLINE419	<p>1) A form should be enclosed with the initial claim pack, and also the decision letter, that we must be kept informed to all changes in circumstances.</p> <p>Also, a heading in bold type lettering, should be inserted on the top of page 1 on every form sent to the customer/representative that we must be kept informed of all changes in circumstances.</p> <p>2) The length of time it should take before a decision is made. Also, the type of information that will be required in order to qualify for the benefit.</p> <p>3) No Comment</p> <p>4) I am not in a position to make a comment on this question.</p> <p>5) The conditions to qualify for benefit should take into account that all children have a certain amount of needs, Therefore, to receive the benefit normal needs should be exceeded.</p> <p>6) Although this is an important point, it is outside the scope of my daily duties.</p> <p>7) Again, this is an important question but I am not in a position to comment on the implications of using or not using the benefit as a passport to other benefits or services. This question would be better suited to a person in receipt of benefits.</p> <p>8) I am unable to comment on this question.</p> <p>9) All groups concerned should be made aware of the proposals through relevant charitable organisations and support groups.</p> <p>10) No</p>
ONLINE420	<p>2) assess certain severe disabilities in the same way as now.</p>
ONLINE421	<p>2) If a person has been diagnosed with a progressive illness they should remain on the benefit and it should be completely unchanged. Living with that uncertainty is punishment enough without having to endure the anxiety of possibly having to justify why they have received the allowance. Similarly if people have provided medical evidence and also been assessed by the DWP doctor they should not have to go through the whole traumatic process again.</p> <p>3) Transport for mobility impaired people especially as bus services are now ever decreasing. Should they have to reduce working hours it helps to ensure their standards of living are not drastically reduced. It can help pay for desperately needed help around the home. Whatever it is for it is needed.</p> <p>4) It will cause problems inevitably simply because it is new - why does it have to change at all. This Government so far has made life more and more difficult for hard working people and has absolutely no concept of the problems faced by falling income and rising prices</p> <p>5) It should be automatic for some conditions especially progressive ones with no cure</p>

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	<p>6) Getting out, feeling wanted and not a burden</p> <p>9) Like all Government forms they will be ambiguous and hard to understand so why cannot things be left as they are for existing claimants</p> <p>11) No health professional can know every single health condition - why put people through this?</p> <p>12) For progressive conditions there should be no reviews. If the disability has a cure then possibly an annual assessment.</p> <p>13) People have enough to worry about in their daily lives when coupled with coping with disability - it will be difficult to encourage them to report changes.</p> <p>? ) The whole process is shameful - it is purely a means of saving Government money. It is widely known that benefit take up is not at 100% level so in essence more people would probably qualify. Why are this Government intent on destroying the lives of disadvantaged people in a feeble effort to reduce a deficit that was in no way caused by any of these citizens.</p>
ONLINE422	<p>1) Lack of access to buildings, restaurants. Even with new laws.</p> <p>?) Very useful, with some people just knowing you receive DLA at the highest rate opens many doors and saves time.</p> <p>2) The extra points for epilepsy The award for life for lifelong severe genetic conditions</p> <p>22) More form filling, more stress, more aggravation dealing with different departments.</p> <p>3) Fuel for cars, disabled friendly public transport is a disaster. Continence needs including wipes and bags. Extra electricity for washing. Holidays for disabled are more expensive. Heating costs, Hiring carers to assist.</p> <p>13) One full assessment should be good enough for all government and public sector departments.</p> <p>4) Two rates to define all types of disability? How are you going to do that, there is such a range of disability.</p> <p>5) Where a claimant has a life long severe and genetic condition it is obvious at the level of disability and it is pointless doing an in depth investigation. Where a claimant has a 'bad back' or similar then of course you should do full investigation</p> <p>6) Being able to go out and about when you want to, not when others are available to take you out. Having a choice.</p> <p>7) Have a review every few years?</p> <p>8) Aids should not be taken into account, disabled people only need them because they are disabled. Having a wheelchair is not the magic key to a new world. Plenty of places are still inaccessible to wheelchairs including many pavements and kerbs, shops having steps going into them,etc. Is someone who uses a hoist, shower chair, wheelchair, downstairs accomodation to have their benefit reduced? someone who is severely disabled should not be penalised for needing aids. This is obscene. You cannot consider aids that person does not have or might be eligible for, they may be totally unsuitable for them in reality.</p> <p>9) Stop asking the same questions on different parts of the form, we know this is designed to catch us out. Have a different shorter form for those who have been receiving DLA for some time and have a severe life long genetic condition. Employ less rude staff at your call centre, and assume claimants are genuine until proved otherwise</p> <p>10) Consultant first, GP second, NHS therapist third, then social worker etc.</p> <p>11) Face to face is fine, if the claimant can talk, Will you accept an advocate to talk for them? Again in the case of severe, life long genetic illness a face to face may not be necessary</p> <p>12) Yes, 'bad backs' should be regularly reviewed - annual review maybe. Severe life long genetic illness does not need to be, maybe once in 5 years, or just write to the consultant</p> <p>13) don't know</p> <p>15) How can you force people to take advice? To be honest there is plenty of access to advice now, social service, OT, physio, consultant.</p> <p>16) Cars are currently funded using DLA mobility, maybe they could buy a car with a one off paymnet, but wheelchair adapted cars are very expensive, would a one off payment cover this?</p> <p>17) The needs of the whole family, their disability affects them all. Children away at school</p>

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	<p>will still come home for holidays, this time at home needs to be thought about.  ?) The proposal to take away mobility allowance for people living in care homes has not been thought through properly. What about children and young people at residential schools and colleges? These institutions close at the end of each term. If a child/young person has a Motability car this will be taken away from them after 28 days in a school/college, How will they then get home at the end of each term? How will they get back to school/college for the new term? How will they get around when they are at home during the holidays if their only means of transport has been removed? Public transport is useless for the disabled. Adapted taxis are very expensive and who has the money to use these daily?</p> <p>The Government line that there is duplication and overlap with mobility allowance and care homes is rubbish. The schools/colleges do not provide transport to take students home or to take them out and about when they are at home in the holidays. So where's the duplication then? The Government has also said they wish to bring it into line with people in hospital. How does being in college compare to being in hospital? Who linked the two together and decided that if a disabled person goes to college that is the same as being in hospital and therefore they should lose their mobility allowance, lose their car!! If the Government had said that Claimants living 52 weeks a year in a care home would lose mobility allowance then that is another matter. But the statement that they will lose it after 28 days shows a complete lack of awareness of the lives the disabled lead. Schools/colleges close!!! Students go home!! Students have a life in the holidays and need their own transport, more so if you require an adapted car paid for by mobility allowance. Why should they be housebound during the holidays? How about an answer to this?</p>
ONLINE423	<p>1) anyone in a wheelchair knows the problems leading a full and active life. My husband has been in a wheelchair for 14 years. which I have to push. Our lives are very restricted. Many buildings are not accessible, every cafe we go into, I have to find out first if there is a disabled toilet. There are problems getting across roads because we have to find a dropped kerb (and hope that someone has not parked across it.) Even one step into a building makes access impossible.</p> <p>3) If you want people in wheelchairs to lead "full and active lives" why are you even THINKING about taking HRM away from them because they can mobilise their own chair. One of my neighbours has had a severe stroke- he can no longer drive but can use a scooter. He is restricted to riding up and down the village High street where we live. I would not call that a full and active life. My husband can't propel his chair due to O/A in his shoulders. If he could propel his chair he would be restricted to about one mile radius where we live. What about getting a wheelchair in and out of a car? Unless you have someone to do that for you, there is the cost of buying a hoist.</p> <p>5) There are some health conditions that will never change ie severe learning difficulties such as autism. Once they have been assessed they should not have to apply again.</p> <p>7) by taking into account the fatigue which comes with trying to get around with elbow crutches, or mobilising a wheelchair. Also the lack of sleep because of pain.</p> <p>8) wheelchair users are restricted how far they can go. Even battery chairs can only go a few miles. Hardly a full and active life! I don't think an individual's ability to get about in a wheelchair should count. Life is difficult enough for them.</p>
ONLINE424	<p>2) The three care elements should stay the same and the medical test of three months, bearing in mind that most people have had problems long before they get a diagnosis from the doctor. Who will be able to assess how long an illness will last. It should be made easier to claim. At the moment it is so difficult that a lot of people who are eligible give up. The reforms are not being made to make the accessibility to the benefit easier, it is being made harder so that the government will save money.</p> <p>5) Claims are already based on need and circumstances. To claim DLA a disabled person has to show that they have specific needs and how it impacts on their day to day living. Your most personal and basic needs are assessed and clients find it difficult to discuss personal problems with a stranger. DLA is extremely difficult to get and the majority of people are turned down and that is why appealing has an 80% success rate. DIA is already very difficult to claim and a large proportion of people who should be getting don't. What does functionality mean this assessment will become the same farce as ESA where client are not listened to or are allowed to explain the impact of their illness</p>

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	<p>on their daily life.</p> <p>11) Most health professionals employed by the DWP do not listen to clients. They have targets to reach. Clients are not allowed to express how their illness affects them or any difficulties they have. They have closed questions which gives them no chance to explain their situation and the problems that they face. It is hard to discuss your most intimate problems with strangers that you do not know, and who have a time scale to complete. We have found that most clients don't even tell their doctors of the difficulties they experience as they find it demeaning and degrading to explain that they wet the bed or themselves. Most of our clients have face to face with health care professionals in their home, whose assessment is questionable as the client disagrees with their report and said that they spend very little time with them and they don't listen to them. As long as they can stand they are assessed as not being eligible. Also questions are closed.</p> <p>One client seen by a healthcare professional was assessed as being able to walk 700 metres, bearing in mind that this client walked with a stick and was asked to walk ten steps and fell over and was helped by the health care professional, but he deemed that client was not eligible for DLA. At appeal and award of higher rate mobility and middle rate care. This client's disability had been there for about 5 years and had been turned down for numerous claims of DLA. DLA is very hard to claim.</p> <p>?) Disabled people would have no quality of life. DLA is there to help people live with their disabilities and accepts that disabled people have specific needs which are more expensive than able bodied people. The purported benefits make a huge difference to their quality of life, for eg people are able to afford nutritious food, they are able to keep warm, they can pay someone to help with the tasks that they cannot do,</p>
ONLINE425	<p>1) lack of enforcement of access regulations with many public buildings and leisure facilities. Lack of suitable public transport. Lack of affordable, reliable care assistance.</p> <p>2) mobility allowance and benefits</p>
ONLINE426	<p>1) There are many. Some are universal- health, safety, basic getting about (not just mobility- being about for taxis to special schools etc). Others more specific- aggression, verbal problems and other communication issues, access, attention deficits, fear if you have a phobia, simple inability to make contacts (eg with Asperger's Syndrome). Then there is access, both to buildings but also to user groups- very few ever have vacancies. Also, difficulties within the family or relationship that are a result of the special need- eg exhausted parents who would use DLA to purchase respite support that Social Services struggles to provide. Basically, each case needs to be assessed by someone with a working knowledge of the type of disorder- physical disabilities cause a very different set of issues to psychological ones or learning difficulties, and these vary massively under the umbrella of a diagnosis. There must be a facility as well for different presentations to be taken into account- for example, Asperger's is often seen as 'quirky', but as both parent and professional, I have met children whose Asperger's barely affects them, and others whose syndrome is pervasive and related to extra issues such as eating disorders, anxiety, violence, phobias. There must be a mechanism to take this into account or a lot of people will be harmed.</p> <p>2) The best thing about DLA is that it is based on someone's presenting difficulties, not their label. Labels vary so much, and the current system is far more effective in allocating funding.</p> <p>3) I don't think any one person could sum that up. I have no real concept of what it is to have a terminal disease in the family or a mobility issue, however with my two autistic boys I would say:</p> <p>Replacing furniture and clothes that are lost or destroyed sometimes after only a week (we get through beds at a rate of knots for example).</p> <p>Petrol to summer schemes based many miles away (there is no bus there). Likewise school placements and reviews.</p> <p>Special diets.</p> <p>Therapy the NHS cannot provide.</p> <p>Support and help around specific issues such as behaviour management and education.</p> <p>Respite, which our LA cannot provide and which is all that keeps us afloat.</p> <p>Access to safe play as we cannot use parks and free play schemes- the boys run away, or pick up discarded bottles and food.</p> <p>Entertainment and socialisation of children who do not have friends or who cannot get out</p>

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	<p>about with schoolmates as they cannot go out without supervision.  Childcare because our needs are so tied around the taxis that taken to disant educational placements- only childcare we could use would be an Au Pair or Nanny absed at home, but that is the type it is ahrdest to get help with.  Extra educational support for children struggling to keep up at school.  4) It seems obvious that a two rate system is less sensitive and that it will either discard the bottom section of claimants, or move them up into another category. It's important that the rejig does not cause people's rates to be lowered just because the system has been changed rather than as a matter of imprvoement in their condition. That would be most unkind.  5) I think with children, any child who has a statement of special needs issued by tehir LEA should have automatic assessment with an assumption of entitlement: it is very ahrd to get these and no child with one does not need DLA.  Terminal illnesses should automatically get access to DLA, as should any child who cannot attend their lcoal school because of their SN, or is in a wheelchair.  6) If you prioritise then you are deseleting other areas which will negatively impact. The assessment should look at someone's whole life: employment (with children, of the family members), social life, self care and psychological effects and make a holistically based decision. The WHO defines health as 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' and there needs to be attention paid to that when looking at DLA. Dependence, isolation and poverty are all horrendous results of disability, and it is the vulnerability of someone to those (dependence on satte as well as a carer) that matters.  7) Many disorders are invisible on occasion, and these are disorders for which DLA can be a nightmare. My own specialism is autism (as well as being a prents I am studying for an MA in the subject). It can be impossible for someone with an Autistic Spectrum Disorder (ASD) to be assessed accurately in a visit- because they cannot ask for help (a recognised effect of verbal ASD), are scared, their reactions and understanding are delayed... so many reasons. For example, my eler son may appear typical on first meeting; after a few weeks one reaises that is nto the case and he has a palce at a specialist ASD unit in September. During assessment he would appear to be neurotypical, but afterwards would meltdown and there will be inevitable violent repercussions to either ourselves or our otehr children. One criteria for addressing this is as simple as looking into what other services the family access: do Social Services know of tehir existence? Do they attend any support groups or similar? What are the longer term impacts on a famillies life? Because the most important aspect isn;t whether they have issues once a week or once a day, but how pervasively it affects their life and those of the people around them.  8) We don;t use and aids or adaptations, but I think it is essential that these remain the responsibility of Occupational therapy and are not considered, as I can think of several scenarios where disabled people could be forced to choose between an aid or essential bills and that would be unfair.  9) The form IS ahrd to fill in, and some sections ahve little relevance- for example my son has speech problems and trying to break that into minutes he needs help with is hard. If a child or adult needs ongoing help with a specific area- supervision, communication, mobility- then it might be sensible for tehre to be a box stating 'This person needs this constantly' that teh applicant can tick, and then allows them to skip the minutes per hour bit. On the whole though, much as the form is hated, I do think it screens people effectively and I for one have no idea how anyone could ever claim fraudulently!  10) As now, people who know the child in the longer term. Of course, with the cuts and shrinking services, it will be the case that more and more applciants struggle to find professionals to help them that can fill in the forms and that must be remembered.  11) Inappropriate in cases of terminal illness or where person has a very clearly lifelong disability- eg a friend with quadripelgic cerebal palsy who has an assessment every two years; it seems a pointless act of administration, tehre is no cure.</p> <p>With people who ahve mental health issues or isues such as autism the erpson assessing MUST be someone with a knowlkedge of these disorders; there are enough applciants in this category to warrant properly qualified recruitment. People with an autistic diagnosis typically underplay their needs and struggle to ask for help, or may not even understand how they differ from otehrs as a core part of tehir diagnosis. Other may find the whole prospect so stressful it precipitates aggression or distress either during, before or agfter the</p>

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	<p>assessment and</p> <p>any assessor needs to know that all they see is a snapshot, that carer's reports are equally valid, and that if a carer's report is backed up by eg a statement of special needs that mentions the issue then it should be taken as truthful.</p> <p>12) Reviews MUST vary on the nature of the disability. We all know some conditions never leave a person and those people should be reviewed less often than those for whom there is a potential cure (eg autism less than a bad back). if a disability is obvious either by watching the person or because of their whole presenting package- school support, care needs etc- then telephone reviews may cut it for every other review (and cut costs).</p> <p>13) People are scared that they have to ensure the whole application process again for quite minor changes. It should be possible to review only a segment of an application without starting from scratch. The DWP also need to be clear about time spans: for example, if your child's symptoms with regards to sleeplessness improve or deteriorate for X weeks then contact us- currently so many conditions fluctuate that people don't know when to go from expecting a return to normality to reporting a change.</p> <p>?) At the moment it really only passes to Carer's Allowance: I think that should be extended to social housing and qualify the claimant for an automatic assessment by social services.</p> <p>?) Carers would struggle hugely, and many (quite possibly myself) would have to consider residential care for their child. Nobody with a disabled child needs extra paperwork and admin, and given that many have more than one disabled child or family member it can simply be too much, especially at the very vulnerable time of first application..</p> <p>?) Changes scare people and people are widely scared they will be left without access to support in a very vulnerable situation. We understand the desire for reform even if we would prefer it stayed the same, but a cut aim of 20% confirms to people that many genuine claimants WILL lose out and there is a lot of fear.</p> <p>?) Clarifications of terminology, criteria for awards etc- and yes, as much info as possible.</p> <p>?) Ease of access, and the implications of home assessments on groups for whom such things cause a major issue- eg those with mental health disorders, autistic spectrum disorders etc. Accessibility for those with non visible disorders.</p> <p>?) Information sharing is a high risk field, but with children there are already options such as statements- the best thing in my opinion would be to include a form asking the applicant to state which sources of information are both available and acceptable to the claimant to be viewed: for example, if a statement of special needs is being disputed that may not be, but otherwise it could be an easy tool.</p> <p>?) No, I think that clouds the boundaries between benefits. Most people use grant funding or social service grants for this purpose and that should remain.</p> <p>?) Simple things such as the value of maintaining or encouraging access to childcare to keep a family in work so overall benefit dependency is minimised; it's a key issue those with disabled children face, and lack of childcare costs the nation huge amounts each year. The current system of comparing to a neurotypical peer is correct in my opinion.</p> <p>?) Yes, and by as many means as possible. Different sectors of the disability community have different needs and for some a home visitor is essential (a job I'd love actually) whereas many others would prefer telephone advice, and there is a core section especially in the autism sector who find email far easier to use.</p>
ONLINE427	<p>1) Problems &amp; barriers for Disabled People (DPs) are as varied as the varieties &amp; combinations of possible medical conditions. What is a problem for one DP is not necessarily the same as for another DP, even if they have the same medical condition. The social model of disability states the broad categories. Not all the problems can be solve by aids, changed attitudes etc but they can be eased. Often it is the DP's own fears &amp; insecurities eg fear of being conspicuous, fear that it will hurt, that cause the problem. Current disability legislation has not solved all the barriers eg many buildings remain inaccessible for wheelchair users.</p> <p>2) As Mobility &amp; the Blue Badge schemes depend on receipt of the higher mobility rate, it is useful to separate the mobility needs from the care needs.</p> <p>3) The particular extra costs depend on the individual &amp; the nature of the difficulties they face. They include:-</p> <p>Carers to help with basic activities eg getting up, going to the toilet, bathing, eating. Some DPs have to pay for day care or residential home care.</p> <p>Often a companion is needed to guide, support or help DPs, especially when they are out</p>

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	<p>of their home. This often doubles the cost of entry to theatres etc &amp; of transport. It tends to be only the more expensive hotels that have been adapted for DPs. If a DP goes abroad they often have to hire cars, special equipment, even transfers from airport to hotel as they are unable to get on the coaches most package companies supply.</p> <p>A car is a necessity rather than a luxury for many. Some have to rely on taxis to get around.</p> <p>Many people have extra fuel costs. Extra heating is needed if one is unable to move around much or as a side effect of some medications. Extra electricity is also needed for many aids eg hoists, electric wheelchairs, chairlifts.</p> <p>If incontinence is an issue, there will be extra laundry costs.</p> <p>Most DPs have several items of medication every month, each of which they have to pay for until they are 60.</p> <p>Many aids &amp; adaptations have to be paid for either because they are not available through local authorities or the NHS, or they are means tested. If cars need adaptation then it is the DP who must pay.</p> <p>Special, often expensive, diets are essential for some DPs.</p> <p>Insurance costs remain higher for many DPs. This particularly applies to travel &amp; driving insurance.</p> <p>Many DPs benefit from therapeutic therapies eg aromatherapy, osteopathy, chiropractic, not usually available on the NHS.</p> <p>Cleaners, gardeners, handymen (even for something as simple as changing a light bulb), organisers (especially for people with mental health or learning difficulties), all have to be paid for.</p> <p>4) Obviously it will make it administratively easier to have only two rates. Any other advantages or disadvantages or problems depend largely on what the criteria for the rates are. They are not indicated in this document.</p> <p>5) Being blind, deaf or an amputee is inevitably going to cause problems. A DP's ability to do things on their own is, to a great extent, dependent on their own ability to adapt, to learn new ways of doing things, &amp; on their determination to be as independent as possible. A lot of disabilities, once they have merited the entitlement to benefit, are always going to merit it. If anything they are only going to get worse. It seems an expensive waste to continually reassess them unless there is likely to be some improvement in the treatment of that medical condition. The ease of coping with the problems is largely a reflection of the DP's own perseverance &amp; determination. They should not be penalised for having it.</p> <p>6) The most basic level, essential to everyday life, concerns bodily functions eg help with bathing, toileting, eating, dressing, getting up &amp; going to bed.</p> <p>People need to feel safe in what they are doing. So if falls are likely they need to have someone to supervise them.</p> <p>Most people require social interaction to avoid depression. For this reason communication skills and/or interpreters are essential.</p> <p>Most people need to feel they are valuable &amp; are valued. They need to feel they can do something worthwhile. For many people this is why work is so important. However this is difficult if there is a lack of concentration, or problems of fatigue.</p> <p>Most people need stimulation &amp; a change of scene from time to time. For this reason, for many people, especially DPs, holidays are essential. It has to be accepted, though, that for some, the familiarity of their home is equally essential.</p> <p>They also need to be able to access educational possibilities, books etc. Mental activity becomes all the more important when one's physical capabilities reduce.</p> <p>For their general fitness, DPs need to be able to access suitable sport activities eg wheelchair basketball, riding.</p> <p>People need to feel they have some control over their lives, to have choices which they can make. They may need assistance to organise this, especially if they have learning difficulties or a mental health problem.</p> <p>Most people need to feel independent, however illusory it is.</p> <p>DPs need to be able to participate in all aspects of life, to marry, to have children, to pursue religious, sporting &amp; cultural interests, to do all the normal things everyone else can do. Unfortunately this is not always possible whatever money spent on trying to achieve it.</p> <p>7) All questions need to be asked in terms of what a person can reasonably be confident of being able to do next week or next month.</p> <p>8) No. The assessment should not take them into account except in a few cases. Clearly</p>

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	<p>small aids, universally regarded as useful &amp; easy to use, eg the wearing of spectacles &amp; hearing aids, should be.</p> <p>The only value in taking aids an adaptations into account is that it may give an indication of the severity of need. It must be remembered, though, their absence may be a reflection of the applicant's ignorance of what is available. No matter how desirable some aids may seem to be, some people find them too difficult or too uncomfortable to use. Indeed sometimes a DP can achieve more unencumbered by the aids that theoretically should help them.</p> <p>The ability to use most aids &amp; adaptations is often the result of the DP's own determination to regain their independence. They usually involve a certain amount of extra effort on the DP's part. Neither the person who uses aids nor the person who does not should be penalised in the assessment of their needs. Their needs are the same. The former may be discouraged from trying to use the aids for fear of losing his benefits; the latter may just not be able to learn how to use them or have dismissed the aids as being too uncomfortable or positively restricting in what they can do. It has to be remembered not all people can learn how to use aids especially if they have dementia or learning difficulties. Many aids &amp; adaptations have to be bought privately. Often aids &amp; adaptations break down, the DP then sometimes has the cost of repair or renewal as well as coping without them.</p> <p>When going on holiday some aids, eg a perch stool, are impractical to take with you &amp; so have to be managed without.</p> <p>It is only at times when a DP has to manage without, that you realise just how disabled the person is.</p>
ONLINE428	12)
ONLINE429	<p>1) 1. Disabled people need to be looked after by disabled people. No able bodied people understand. I have just been given a completely useless wheelchair by the NHS after 6 months of consultations with so called professionals. I have now bought my own. Main problem, it would not go through any of my doors. At present care given to disabled is incompetent because only disabled understand disabled.</p> <p>2) Your new allowance gives me the 'PIP'. The costs of introducing the PIP will be far more than any savings. DLA should be divided into people with permanent disabilities and temporary disabilities. People with permanent disabilities, I believe, will have a legal right to this money transitionally protected. All of them have rights to legal aid and they will appeal against any legislation that attempts to remove this right.</p> <p>3) The main cost is for care. This varies with each individual. Unlike John Major I believe we have only one family in this country. The British family. We need a care and share scheme. This means people will care for disabled and the disabled will share their homes. Just check your homeless figures! This scheme will be run by the churches and charities. The governments roll should be restricted to the planning.</p> <p>5) People with permanent disabilities should get permanent allowances, as should the terminally ill, both without red tape.</p> <p>6) Human Rights article 29 states we all have a right to develop our personalities. This is often denied to disabled people because of lack of understanding.</p> <p>7) ASK THE doctor of the disabled if they need the allowance and get rid of all your costly beaurocracy.</p> <p>8) Only the disabled persons DR can say.</p> <p>9) It is an impossible form to fill in. Doctor should refer people and complete forms.</p> <p>10) The DOCTOR</p> <p>11) In every case. See my Dr</p> <p>12) Permanently disabled should be left alone. Temp disabled, contact Dr annually.</p> <p>13) DLA should be awarded by the Dr not unqualified Civil Servants</p> <p>? ) DLA is the only benefit to being disabled. Cut this and you make disability worse</p> <p>? ) I have had to pay for all my needs. What is provided by the NHS is costly and useless</p> <p>? ) Let the disabled help the disabled. At the moment motability don't use disabled and neither do local councils providing care. Give the disabled those jobs.</p> <p>? ) Make DLA into a care payment for sick people administered by their Drs. Save the money by getting rid of all the beaurocracy</p> <p>? ) No advice from you</p> <p>? ) The government needs to get its nose out of a problem that confronts the British family.</p>

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	<p>DLA is a benefit for sick people and should be part of an independant health service            ?) The mother of a disabled child should answer this            ?) Your proposals give the disabled the PIP and take away their only benefit at a time when you have displayed that bankers and others are allowed unlimited funds. Recently the West Sussex CC came and removed my handrail from my door and replaced it with a grab rail. This is supposed to save money? This PIP proposal is even dafter than that</p>
ONLINE430	<p>3) Where the disability is physical almost everything can become more expensive; transport, food, clothing and accomodation. Transport becomes more expensive if the individual has to be transported in their wheelchair. Clothing is important because there will be heavier wear and tear and off the peg clothing rarely fits. With housing the cost of heating is significant for someone wheelchair bound as they have more difficulty maintaining their own body temperature and they are less active.</p>
ONLINE431	<p>21) As a theoretical equality policy document, the main principles appear reasonable. However, as there is no clear indication of how the assessment would be made in practice to determine which claimants had lesser barriers to achieving independent lives the current details laid out are premature and need further substantive content to be properly assessed.</p> <p>1) I have a significant physical disabilities, but an unimpaired mind, and I find the tolerance many members of the public show to disabled people is reducing, together with a distinct lack of respect. Everyone appears in such a rush, and there is little tolerance for the slow responses from the disabled caused by their particular disability. The abuse of disabled parking bays is but one persistent example. There appears little understanding amongst members of the public that a disability rules and controls the sufferers lifestyle and limits speed of action.</p> <p>1) In my view the medical disability is the primary obstacle impairing a full and independent life, coupled with the side effects of medical treatments available for the particular condition at this time. Some side effects are quite serious. The very nature of disability requires external physical and mental help from other people be that family memnrs, carers, or medical professionals. The are some tasks that disabled people simply cannot physically do because of their condition. There is generally less understanding / patience / compassion shown to disabled people by the general public who mostly appear to be in a rush to get anywhere.</p> <p>? ) As an access portal to universal benefits</p> <p>2) Funding support for provision of personal transport.            Provision of carer support from any source, family, carer, medical professional, &amp; medication.            Provision of support for payment of added cost of basics to cope with disability - food, utility bills,etc            ?) In my view it would be disastrous.            Coping with serious disability is very trying in its own right, and the easier the administration supporting the patient the better it is for the recipient, increasing his/her quality of life</p> <p>3) MAIN EXTRA COSTS            Personal Transportation at any time 24hrs per day. Trips are shorter and more frequent than normal work transport. Heavy wear on vehicle.            Home heating &amp; stabilising atmosphere to promote health and prevent respiratory infection.            Extra costs of specialist diet and drinks to help manage disability, PLUS the costs of getting those supplies into the home.            Extra cooking costs and provision of carer for some cooking tasks.            Provision of carer for household cleaning, and maintenance of healthy living environment.            Washing bedding and clothing means there are four times the number washloads than normal per week. This has high energy costs and uses much more detergents / softening agents / water. Provision of carer as required.            Bedding, pillows, outer clothes, underwear and footwear need replacement twice as often as normal.</p>

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	<p>Most disabled people cannot do home / car DIY and must rely on outside care help / professionals, the cost of which would not be necessary if they were not disabled.</p> <p>Daily provision of carer for getting showered , washed, dressed according to need.</p> <p>13) Medical record and DWR assessment could be shared with local authority to access council tax and other benefits avoiding doing everything twice. Perhaps like an electronic version of a one stop shop</p> <p>3) Personal transport (most cant walk any distance).</p> <p>Additional heating, lighting and power costs to maintain health.</p> <p>Additional Bedding and personal clothes washload (X4).</p> <p>Frequent replacement of bedding, pillows &amp; cases (X2).</p> <p>Frequent replacement of clothes, undergarments, and footwear (X2).</p> <p>Additional housing repair costs - most cant do DIY as normal people do, so have to pay outside contractors.</p> <p>Additional vehicle repair costs - most cant do car DIY as normal people do so have to pay outside garage for work.</p> <p>This is just a small example of the main tasks involving extra costs, but there are many more smaller problems where another persons help has to be sought because the disabled person cannot carry out the physical tasks they were previously capable of doing. The depth of the lifestyle change has to be experienced to be fully appreciated.</p> <p>4) Two rates will not necessarily make the benefit easier to understand, administer, or guarantee appropriate levels of support.</p> <p>The real answer to the question lies in the definitions of eligibility applicable to each rate, the amounts of rates to be granted and the differential between the rates.</p> <p>Only when this information is available can a meaningful answer be given.</p> <p>Unless careful attention is given to definitions of eligibility, applicants could be unduly pushed into being granted only the lower rate, with the higher rate having such stringent access criteria very few would be eligible.</p> <p>With three rates, the sharpness of the impact of any cut off point would be lessened.</p> <p>The use of two rates therefore may have the potential to reduce the ability of the patient to achieve an independent lifestyle.</p> <p>5) In my own personal experience most claims could be reasonably dealt with on a needs basis. However my daughter suffers from Downes Syndrome, and she will never get better. So, I think there are some specialist disabilities which could sensibly attract automatic entitlement.</p> <p>5) Some patients with lifelong conditions should have automatic entitlement.</p> <p>Others could be by assessment as normal, except where an assessed applicant develops a lifelong condition after the assessment. They should then be able to change category.</p> <p>6) I think looking at the diagnosed medical condition of the patient must be the first step in any assessment irrespective of the scheme used.</p> <p>The assessor MUST have a clear understanding of the medical condition, and the impact it is having on the patient - different people have different degrees of capability, and the assessor must reach a judgement on the reaction of the patient to the problem.</p> <p>Based on the assessment of how the patient is coping with the disability gives a clear answer on who to prioritise with support.</p> <p>Firstly, in my view the right to family life is the cornerstone of a happy home living environment, and aids the patient in coping with the stresses involved.</p> <p>Secondly the right to get outdoors, and enjoy the environment is an essential building block to achieving a contented balance, and building confidence.</p> <p>Thirdly, the two former combined factors allow the individual the right to make an informed personal choice over which hobby / activity / or work to undertake, building their confidence.</p> <p>Everyone needs an interest - when you have a disability sitting on the couch watching TV is not an option.</p> <p>6) In my view the disabilities suffered will provide the key guide to who needs help most, as they the condition will point to those least likely to be able to lead a full and active life.</p> <p>Looking through the eyes of a disabled person.</p> <p>The first essential is to wake up in the right frame of mind in the morning - everything else is a bonus.</p> <p>Access to a refreshing nights sleep is vital in maintaining good health and spirits, to be able</p>

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	<p>to deal with the pain and rigors of the coming day. Warm, comfortable and clean bedding is essential to achieving this, coupled with access to a shower / bath.</p> <p>Getting around the home requires various aids, and moving outside requires a vehicle close at hand for transport to do the myriad of things each person needs in daily life. The correct clothing for the outside conditions needs to be close at hand in a central location, and each part of the day is planned in advance taking into account the disability.</p> <p>The disability is the controlling factor determining everything that can be done on the day. If its a bad day, one can do very little, and may be forced to stay indoors.</p> <p>When moving around outdoors I take advantage of every support I can lay my hands on to help mobility.</p> <p>7) The previous DLA scheme was in my view too focussed on the medical condition getting better rather than objectively assessing the facts on the ground.</p> <p>As an example in my last 5 year review although I clearly stated I had developed a serious Atrial Fibrillation heart condition on top of my Perthes disease disability, and was being treated by a cardiac specialist, the assessor took no notice of the new information, concluding I should be reassessed in 12 months time as I may get better.</p> <p>The Perthes disease and Atrial Fibrillation are both lifelong conditions I intend to write to DWP pointing out the error in the assessment.</p> <p>The bottom line is I believe there should be a simplified departmental review every say three years, and there should be a reporting facility from the patient at any time to include medical/needs changes.</p> <p>7) The spacing of review assessments will be crucial, but I also think patients should be encouraged to report any worsening in their condition as and when it occurs</p> <p>8) NO. THERE SHOULD BE 2 ASSESSMENTS UNDERTAKEN AT THE SAME TIME The purpose of the assessment is to ascertain the ability of the patient to live a full and active life, and that assessment should be separate to any aid which may be used to ameliorate the condition.</p> <p>Disabilities can worsen and should be assessed in their own right to give a clearer picture over time. The value of any aids to the patient can then be taken into the picture, including modernisations or upgrades of the device.</p> <p>8) Yes - any aid genuinely associated with the disability Yes - any aid already possessed if genuinely associated with the disability ( requirement can change over time depending on disability impact ) Yes - any aid which the patient may be eligible for and can be genuinely associated with the disability</p> <p>9) Remove the Civil service gobbledegook The use of plain english would be helpful set at a more simplistic level for those lacking a grasp of English, or using English as a second language</p> <p>9) The language used needs to be more welcoming and less civil service oriented. The use of plain english would be welcome, and reduce the bulk of the text to make it less daunting to the user.</p> <p>Definitions of eligibility need to be simple and plain.</p> <p>10) The best and clearest evidence is medical records which outline the basic problem. How than effects each individual is only really know by the patient themselves. In cases of exaggerated claim of impairment, medical review from a healthcare professional is the only real alternative.</p> <p>10) The definition of the medical condition must be the starting point, provided by a GP etc, with the explanation from the applicant as to how each medical condition listed has an effect on his lifestyle.</p> <p>This could be supported by a wife, partner, or other relative, who often see more than the patient.</p> <p>11) The patient can potentially gain advice on how best to proceed with coping with their disability in day to day life, provided the interview is held in a positive and helpful manner. I think anyone who is mentally impaired or cannot repreent their own affairs should be exempt interview, and medical record relied upon</p> <p>11) The patient may benefit from advice from a healthcare professional, but some people are nervous by nature and care would be needed in presentation. Where the patient is not capable of managing their own affairs a meeting may prove pointless, even with a carer present</p> <p>12) I think normal reviews should be every 3 years, with the patient encouraged to report any medical deterioration at any time.</p>

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	<p>Where lifelong conditions are concerned I think reviews should be every 5 yrs to ansure statutory conditions are met.</p> <p>12) I think that where the condition is lifelong there is little point in carrying out frequent reviews, and these should be limited to say 5 / 7 year gaps. In normal circumstances the review would be reasonable every 3 years. It should be possible to switch between groups as the conditions worsen. As a general rule I think any review should aim to carefully match the ability of the patient to answer questions to the complexity of the questions asked</p> <p>13) The most direct penalty for not reporting changes would be as at present - repayment of the overpayment as a recoverable overpayment - not involving a departmental error. To be realisitic, most people with serious disabilities have enough to cope with on their plate, and can be absent minded.</p> <p>13) There will always be people who will be reluctant to report improvements in disability, and that should be picked up in review. Patients should be encouraged to report deterioration of their condition at any time.</p> <p>14) I think an overview of the linkages on how the new benefit relates to other multiple benefits would be most useful. Which windows the PIP opens. I would also think disabled equipment links and personal transport links would be very useful. Perhaps dedcated one stop shops at City Councils and CAB offices would be most suited to deliver this advice</p> <p>17) The level and quality of parent / carer / guardian support available to the child in assessing the overall package.</p> <p>The actions and dedication of the adult in the equation is the single most important factor in achieving success.</p> <p>?) disastrous</p> <p>?) I think advice and information on coping with disability to try to lead as normal a life as possible at time of assessment and review would be beneficial all round</p> <p>?) I think information links between the DWP and local authorities could be improved both ways, contributing to each other and avoiding duplication in form filling etc. Most disabled patients also claim one benefit or another from the LA</p> <p>?) I think mostly from loans, or small amounts saved. It would be a great concept if PIP could directly fund aids to patients - fits in with answer above re penalties for not taking action to ameliorate disability.</p> <p>?) I think that any reductions to a persons entitlement to disability benefit should give plenty of notice of the change before the date it is due to take effect. I would suggest it is only reasonable to do so to enable the patient sufficient time to adjust to a new household income brought about by new legislation. Sometimes this will be in cases where the previous DLA has been paid for a significant period of time, and through no fault of their own will lose income.</p> <p>?) I think that as children are not fully developed in managing their own needs to lead a full life, the contribution the parent, guardian or carer makes to that equation is essential. For that reason I think the parents need assessing to help determine how they will cope with the childs disability and what level of support the parent will need in achieving that end. To my mind there are therefore two separate assessments which need to run side by side as they are wholly interactive</p> <p>?) I think there needs to be more detail to make a proper judgement</p> <p>?) In my own case, DLA has been significantly helpful in this aspect, as I can remeber a time before these benefits were in existance. I think the model of the one stop shop in electronic form would be ideal to help patients find their way around the linkages. Information is the key</p> <p>?) In the medical side of the assessment it would be normal good practice to provide advice and information to the patient on how they can improve their lot. If they do not take that advice and provide no good reason why, they should receive a warning of potential financial penalties for not doing so. If there is then another failure to respond to the advice without good reason, then the element of the benefit applicable to the disability which could be ameliorated should be withdrawn. The withdrawl would be subject to right of appeal to tribunal.</p>

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ONLINE432	<p>1) Fear that they are seen as different is a powerful inhibitor. This often leads them to avoid contact with outside authorities or to play down their disabilities which in terms often leads them to miss support they are due. Any system should minimize personal contact with new examiners or authorities. It should also take into account they tendencies to try to "brave out" their disabilities.</p> <p>4) By decreasing the number of components you oversimplify the issue. Disabilities vary greatly from person to person, and their impact varies greatly. The more it is simplified the more inequality will occur. It is insulting to disabled people to assume they can not deal with complexity. What is wanted is benefits to meet needs not simplification. Therefore a decrease in components is a retrograde step. The rational borders on being the 19th century view that a disability means a lack of intelligence</p> <p>10) The use of third party medical professionals should be used ONLY in very specific limited occasions. To use it more often effectively negates the earlier arguments that each persons disability is unique. It is impossible for the examiner to give a fair and accurate assessment of the impact of the disability in a meeting of about 1-2 hours.</p> <p>Many disable people try to show themselves as able as possible and therefore underplay their condition. This can be more prevalent with new contacts in pressured situations.</p> <p>The logical result of this is those disabled people who "know" the system getting the benefits they need, while many who are in real need failing.</p> <p>As most disable people have a GP and a Consultant working on their case it should be their responsibility to give a proper analysis of the condition and its impact. This can then be supplemented by carers and others. Only where there is a real confusion or disagreement over impact should a third party medical assessment be called for and in those cases it should only be carried out by someone who has expertise in the particularly area not a generalist. This would not only save money in cost of examination but in appeals and reviews as well as having a fairer more accurate result11) In many cases a meeting with an unknown healthcare professional will be detrimental to establishing the individuals needs. There are three main reasons for this-</p> <p>1) Most disabilities are complex situations often with overlapping conditions. Their impact is often unique to a person. Therefore a face to face visit with a new healthcare professional will not be able to attain the real situation. This can only be established by the healthcare professionals who have been treating the individual over the long term. Any other actions would by its nature lead to quick and oversimplified conclusions based on very limited evidence supplied on the random day chosen to investigate the individual. Rather than a considered opinion over the long term.</p> <p>2) Many disable people are proud of the way they cope with their condition and do not easily explain the true impact. This is a more frequent response to people who they do not know and have no real reason to trust with many intimate details. Therefore using these third party interviews will help those who know the system but not those in real need who do not know how the system works.</p> <p>3) There will be an inherent cost of these visits and no matter how good the healthcare professional as explained above many will be inaccurate causing additional cost to taxpayer of reviews and appeals.</p> <p>The only time these type of reviews will add value is where there are genuine differences between the medical experts and or carers on the individual case. Given the sensitivity the decision on whether to be at the individuals home or another location should be with the individuals consultant of GP.</p> <p>12) The decision on whether to review or not should be based on the individuals medical condition and recommendation by the GP and consultant, in the same way the recommend other diagnostic tests. Initially the review should contact the healthcare professional who deals most with the individual GP or consultant. They can then recommend if further information is needed.</p> <p>The plan to make this review similar to the original review is wasteful in the extreme. A more cost effective approach and one likely to lead to more accurate results is to look at the individual case and via medical advise decide what is likely to change. These then are the items which should be reviewed ( a simple Pareto analysis or equivalent can be</p>

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	used)not the entire case back to basics as that just generate costs for the tax payer.13) The best way to ensure transparency in this is to make it very clear why the benefits were awarded and what "trigger" changes. For example if someone gets the benefit because they can not walk more than say 10 feet with out sever discomfort then the individual should be asked perhaps in writing annual (or at interval relevant to their condition) if that is still the case. The question should be clear and straight forward.
ONLINE433	3) I am a disabled person. In addition to mobility and care costs, it should be remembered that disabled people have extra costs because their disability often prevents them doing the most basic D.I.Y. tasks to maintain their homes in a livable and hygenic condition.This means they have to use expensive tradesmen for jobs like wallpapering, cleaning painting and gardening or even changing a lightbulb. Even a simple task like cutting toenails may mean an expensive visit to a chiropodist for someone who lacks the vision or dexterity to do it themselves.People who are disabled and in receipt of DLA often need multiple perescriptions but do not qualify fo r free prescriptions and therefore have to buy pre-payment certificates.
ONLINE434	1) For people without severe disabilities one of the main problems is access to work with all the positives that follow including greater self esteem, financial independence and social inclusion. Extra financial support is helpful but not the whole answer and can lead to a reliance on benefits, barriers to work need to be removed.
ONLINE435	2) My DLA allowance states it is granted "INDEFINITELY" how can this be legally?
ONLINE436	<p>1) Disabled people have many different needs that erect barriers to participation in society. These include problems caused by mobility: access to many buildings, and both public and private transport is limited. Problems also include the need for personal care and assistance: without these many disabled people are prevented from fully participating in everyday society. There are many expenses associated with being disabled, from the provision and servicing of equipment, and the provision of personal care, to the simple fact that disabled people are often unable to access cheaper options in terms of housing and travel, which non-disabled people take for granted.</p> <p>?) DLA has been useful in doing this. Better and fully accessible information provision could enable this to be done even better.</p> <p>21) It is important that all different equality groups have the same access to the new benefit. The perception of added levels of bureaucracy and assessment are likely to mean some groups are less likely to apply.</p> <p>2) That DLA is non-means-tested and not taxable is vital. Disabled people are the best judges of their own needs and how to spend the funds that are available to support themselves. For the purposes of budgeting and planning for the future, it is also important that disabled people with long-term conditions know that the future funding is assured, as it can be with DLA.</p> <p>The link with Motability is also important, and should be maintained if disabled people are to be enabled to keep their independence.</p> <p>22) This could lead to a less joined-up system, which it would be more difficult for disabled people to access and understand. This in turn could lead to disabled people being unable to access benefits that could enable them to live fuller lives.</p> <p>13) It would be possible and possibly beneficial to combine the assessments for the care component with that for social care. Although the adult social care assessment is means-tested, whereas DLA never has been, and hopefully never will be, so there are differences there. Sharing of information should not be done without the disabled person's full consent.</p> <p>3) The many extra costs that disabled people face include:</p> <p>the supply, servicing and maintenance of mobility and other specialist equipment; and the regular replacement of such equipment, which always has a limited lifespan;</p> <p>additional housing costs related to the need for accommodation that is accessible to their needs;</p> <p>cost of personal care for help with a multitude of everyday tasks including personal hygiene, dressing, cooking and eating, etc, for which it may often be necessary to employ carers;</p>

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	<p>additional costs of getting out and about - it may for example be necessary to use taxis or other private transport where public transport is inaccessible or unsuitable.</p> <p>4) It's hard to see why having two rates will make the benefit easier to understand. The current system does not seem overcomplicated. Having only two rates may in fact make it more difficult to tailor the suitable levels of benefit to each individual's needs.</p> <p>5) Some health conditions or impairments should mean an automatic entitlement, as in the current system, as such conditions or impairments have been identified as creating a need for support. To change this seems to add an unnecessary level of bureaucracy and expense to the assessment system.</p> <p>6) DLA has seemed to do this quite efficiently, when properly applied.</p> <p>Activities that are essential for everyday life include full access to personal hygiene, health and nutrition; the ability to get out and about and to interact with other people; and safety both at home and outside.</p> <p>7) Individual disabled people's own GPs, consultants, physiotherapists or other healthcare workers are usually the best placed to assess their fluctuating conditions, as they will know and understand the conditions. Individual disabled people themselves are often good assessors of their own conditions.</p> <p>8) It's very unclear what exactly is meant by this proposal, but it seems worrying and unfair.</p> <p>If the intention is that a disabled person successfully using, for example, a wheelchair to get around will therefore be disqualified from receiving payments, this appears entirely unfair, and may even lead to a situation where a disabled person might resist using aids and adaptations through the threat of losing their payments. Even the use of a wheelchair does not enable full mobility compared with an ambulant person.</p> <p>It also needs to be taken into account that aids and adaptations are expensive to obtain, to service and to maintain; and that many such aids (for example, powered wheelchairs) have a limited lifespan and will need to be replaced regularly.</p> <p>9) The current form is indeed long, but does not seem too complicated to fill in. It does seem necessary when assessing the needs created by a disability to look at what that disability prevents a person from doing. Access to correct and easy-to-understand information about the benefit is most vital.</p> <p>10) It is an individual's own GP, occupational therapist, physiotherapist and consultant where appropriate, who inevitably have the best knowledge to that individual, and of their abilities and needs. This is particularly important where the individual concerned has a complex and progressive condition, such as many people with neuromuscular conditions, which require specialist knowledge. It does seem unlikely that an 'independent' professional will always have the specialist knowledge that is able to understand the needs of conditions that may be very complex and rare.</p> <p>11) If the healthcare professional does have sufficient knowledges and awareness, this could be beneficial. But it is unlikely that any such professional will have detailed and specific understanding of some conditions, such as rare and complex neuromuscular conditions. This does also seem to add an additional layer of bureaucracy to the system, at public expense.</p> <p>Such meetings can often seem threatening and disturbing for some disabled people - their own consultants and healthcare professionals who know them and their conditions will have a better understanding of their needs.</p> <p>12) It is the evidence and knowledge of the healthcare professionals who know the individual person that make them best placed to do this: GPs, consultants, occupational therapists etc. It would seem that government-appointed 'independent' professionals are unlikely to have the same level of specialist knowledge of the individual, which makes it more likely that an inaccurate assessment would be made.</p> <p>It seems unfair that people should in effect be penalised for the successful use of aids and adaptations that may improve their lives; this runs the risk that disabled people may become unwilling to use such aids, for fear of losing their benefits, and thus exclude them even more from society.</p>

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	<p>For people with long-term, chronic and continuing conditions that have been assessed and identified, it seems that regular reassessment would be unnecessarily expensive, as well as being intrusive and possibly upsetting to the person concerned.</p> <p>13) People need to be provided with information about this that is easy to understand and regularly updated. It also needs to be made easy for them to contact the department with any updated information.</p> <p>14) It would be helpful for disabled people to be aware of any avenues and sources of support that might benefit them. It could be useful to include contact with professionals who are able to offer advice and support on this as part of the application process.</p> <p>15) It is always better to do this in a positive way, encouraging disabled people to see how they could improve their lives, rather than in a negative way that could be perceived as intrusive and even threatening. Disabled people meet enough discouragement and barriers in their everyday lives already.</p> <p>16) Disabled people fund their aids and adaptations through a variety of means. This includes their own income and/or savings, or, in the case of children, the income and savings of their parents. Many disabled people already use their DLA to help fund their aids and adaptations. Some will use other funding and support from government, charities or social services where available.</p> <p>The problem with speaking of 'one-off cost', is that few aids and adaptations do in fact require a simple 'one-off cost' - most will require regular service, maintenance and maybe repair, and most aids are also likely to require replacement after a few years of regular use.</p> <p>17) Children's needs, perhaps even more so than those of adults, often require very specialist assessment. Aids and adaptations used by children may need replacing more regularly as children grow. All this needs to be taken into careful account.</p>
ONLINE437	<p>1) The greatest barriers are society's preconceptions about the limitations that must be placed on disabled people, coupled with the additional financial burden that being disabled brings. The financial problems are exacerbated by the difficulties disabled people have in maintaining an adequate income level.</p> <p>Lack of mobility prevents many disabled people working or socialising with others in any way. Many are forcibly housebound. DLA attempts to address this issue. Especially in rural areas with great distances between centres of population and industry, where public transport is working at the margins, disabled people are given a lifeline by DLA and mobility,</p> <p>For so many disabled people DLA is a passport to work and mixing/interacting with others. Removal of this support will condemn many disabled people to unemployment, poverty and isolation which will in turn lead to increased health problems and additional cost to the taxpayer.</p> <p>2) While Independent Medical Opinion is valuable, this must not be in the disastrous and cynical format that has been used in ESA, resulting in a huge number of successful appeals and a great unnecessary cost to the taxpayer. The Independent system used for DLA must be retained and this work not turned over to contractors such as ATOS whose only interest appears to be to reduce the number of successful claimants by any means. The eligibility criteria also must stay the same for the mobility component.</p> <p>3) The main costs for disabled people are mobility aids, adaptations to home, car and other equipment, and the loss of income associated with disability.</p> <p>Transport costs feature high, whether car/disability scooter or public transport, as these are not optional for disabled people, but necessities.</p> <p>4) Simplification of benefits is in principle beneficial to both recipients of the benefit and the taxpayer.</p> <p>5) The principle of benefits meeting individual needs is seductive, but the cost benefits in cases of severe disability are questionable. There is no doubt the terminally ill must receive the benefit automatically, but there are other illnesses which should automatically qualify such as RA.</p> <p>6) The ability to lead a meaningful life, quality care and maximisation of mobility are essential.</p> <p>7) The current system that looks at the claimant on their worst day cannot be improved upon.</p>

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	<p>8) No. The aids and adaptations are not an integral part of the disabled person. They are an indication of their disability.</p> <p>9) 1. Use plain English, make it user friendly and lose the Civil Service Speak. 2. Do not try to confuse applicants with jargon and complicated conditions. Keep it simple and provide a check list for those enquiring for self assessment.</p> <p>For both questions, use online applications and assessments.</p> <p>11) Where possible, the face to face meeting should take place in the individual's own home.</p> <p>12) Frequency of review should be set on medical advice as improvement or deterioration speed will vary from condition to condition and individual to individual. This fits in with the principle of tailoring the award to individual needs.</p> <p>13) Remove the threat that DWP might use a change in circumstances as an excuse to stop paying the benefit. This fear currently exists both where the condition worsens and where it improves.</p> <p>?) Honest and Fair Advice on eligibility. ?) Ideally all benefits requiring medical examination should use the same information. However, the ESA system currently run by ATOS is so discredited that there would be little faith in such information sharing until a fair and open system is introduced. ?) If this is badly handled, the impact on disabled people would be disastrous. ?) No. There are other benefits that meet this need.</p>
ONLINE438	<p>1) finance, public transport, environment inaccessible, attitudes of "normal" people, health, disability limitations</p> <p>21) you will be discriminating against disabled people and not allowing them equality of life - how does that stack up in law ?</p> <p>?) if I couldn't have my car I would rather die. If I could have my carer and DLA I would not be able to live at home, I would have to go into a home, and then you would take my car, therefore I would rather be dead - how's that for equality ??</p> <p>2) people who have been awarded for life because of an enduring disability should be left alone and new applicants considered by new reforms</p> <p>2) those already awarded for life should be left alone</p> <p>3) Heating, clothing, equipment such as hoists for car, lifts, - platform, stair lift, decent wheelchair. Heating esp in winter is a big problem for wheelchair users who aren't entitled to any allowance, we cannot generate heat and some medical conditions cause poor circulation and therefore need more heating</p> <p>3) heating, transport, equipment, clothing, lifts, hoists, holidays specialist holiday expensive,</p> <p>3) none</p> <p>4) no comment</p> <p>5) enduring debilitating conditions should be automatically entitled - ie polio and the late effects - you only get worse not better. Things like arthritis, I see as a condition not an impairment and yet hundreds of people get DLA.</p> <p>6) we need to be able to do everything that everybody else does to be equal in our society, why should you ask us to prioritise, unless you are expecting a "normal" person to prioritise. The whole point of this benefit is to lead a "normal" equal life, don't ask us to prioritise !!!!</p> <p>7) you have in place now a way for people to inform you - why change it ???</p> <p>8) what do you mean "easily obtain"? equipment is expensive to buy install and maintain [another expense], non should be included. ok I have a stairlift to get me up the stairs, but my carer still needs to be there to help me transfer - what do you want to do , take money away because she doesn't have to carry me up the stairs - this is nonsensical</p> <p>9) don't change what is already working - if this is to save money then you should target the scroungers NOT disabled people -- we feel penalised and it's not fair , believe me I would rather not be disabled and not need this benefit - "there but for the grace of God"</p> <p>10) the person themselves, NOBODY can live the disabled person's life for them or understand what it's like to "walk" in their shoes</p> <p>11) no benefits, how can someone who doesn't know the person decide their fate ????</p> <p>Only the disabled person knows what it is like to live their life. If the so called health professional is given a "script" to work from how can they possibly think they can know the person. What is this going to cost for fees ?????</p>

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	<p>12) you should have been doing this anyway.</p> <p>13) again this should have been done to target the scroungers, NOT genuine disabled people who feel victimised by this whole proposal</p> <p>14) disabled people will be terrified of losing benefit, independence and equality - you tell me how you can alleviate their worries</p> <p>15) no comment = stupid question</p> <p>16) simple adaptations for cars included in motability scheme - I hope to God you are not changing that scheme. Larger equipment all means tested. Wheelchair provided are basic and bog standard any better chair is funded by themselves. home adaptations are provided if it is a council property, home owners go through means testing - don't forget maintenance and servicing as well, all an added expense. I don't think there should be an option within your proposals, we should get equipment needed to live an equal life</p> <p>17) cannot comment on this</p> <p>?) I really think the government should re think their proposals and target the scroungers, this will surely give them the cost savings they are aiming for in this whole exercise. I am appalled at the coalition government and shame on you all for attacking the most vulnerable people in our society - may God forgive you</p>
ONLINE439	<p>?) Not easy or useful.</p> <p>It would be preferable to have an allowance that would allow individuals to fund the extra issues instead of accessing other entitlements separately.</p> <p>1) Prejudice, lack of understanding of need. Social pressures to conform, buildings, people and employers inability to understand the issues and needs.</p> <p>2) There are too many occasions when people are expected to re-apply especially as a child. a permanent condition identified as a baby/child will not resolve itself in adulthood.</p> <p>3) Suitable equipment to enable them to access items that able bodied people can use at ease. Lessons which will aid integration eg speech training. therapies, aids and adaptations.</p> <p>4) Having 2 rates for each component will over complicate the process, negating the reason for reform.</p> <p>5) there should be an element of non means testing for sensory neural losses and permanent physical impairments.</p> <p>6) Being able to undertake the same activities as peers wherever possible is essential for children, to enable them to grow as confident individuals. In adulthood leisure, and sporting activities are as essential as well as working, raising a family, being as healthy as possible.</p> <p>7) Don't understand the question.</p> <p>8) A person should not be barred from funding because they do not use available aids or adaptations eg hearing aids or prosthetic limbs, this eliminates choice for the individual. people may choose to manage their disability in unusual ways and they will need to be supported to do so.</p> <p>9) There is a lot of repetition on the current forms as if they are trying to catch people out. A more transparent approach is needed. Guidance needs to be clearer. Information shared by individuals can be evidenced by professionals and this allows for objectivity. The current form is a bar for eligible claimants. I am aware of a child who was severely brain damaged at birth, is registered blind, barely able to walk with very severe cerebral palsy who was refused DLA on the first claim and following success on appeal her parents have had to regularly reapply. surely this is a nonsense. as her mother says 'are they suggesting that her brain will improve?' if so no one would be happier than her parents, but just like they have had to adjust to the situation, so should the benefits agency without the constant intrusion.</p> <p>10) the reports of suitable professionals.</p> <p>11) If this was done for my son (who is a disabled child) he would minimise his disabilities, his differences and his difficulties. he would hate it and find it extremely stigmatizing. If you do nothing else to alter the proposals, please please alter this. Surely a good alternative is the provision of a report by the professionals known to the disabled person?</p> <p>12) Permanent disabilities should be treated as such. if there is a miracle cure then it should be up to the individual to report it, perhaps this should be supported by a bi-annual confirmation.</p> <p>13) severe penalties supported by regular reminders attached to updates which are sent regularly anyway.</p> <p>14) Advice and information should be provided separately. they are for different purposes and if placed together would minimise people asking for help or advice.</p>

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	<p>15) Absolutely not as part of the claimants system.</p> <p>16) Aids and adaptations are funded from the allowance or subsidised by the allowance. there could be a grant pool as well as on-going maintenance payments.</p> <p>17) the changing needs of children as they grow. The additional requirements for things such as private tuition to support school, or private classes which are often used by able bodied children but also are of particular help to a disabled child eg my child is deaf. He took part in gymnastics for many years which helped him to develop his visual spatial skills as well as self confidence. He currently has Speech training lessons as his speech therapy was a joke. this has to be privately funded.</p>
ONLINE440	<p>1) Having to rely on others for simple things like shopping going out to social occasions etc - granted there is online shopping but if you stay in the house merrily shopping on line...where is the social interaction? It may only be other shoppers/cashiers but it's another human being! If you are unable to go out life very quickly become stale, boring, depressing need I go on?</p> <p>2) The ability to have payments paid towards mobility is essential, The Motability Scheme provides a gateway to the world it gives me and many others a way to carry on working (and therefore carry on contributing to society) it means I can travel to areas otherwise not available to me, I can maintain social contact with friends and family and thus maintain a healthy outlook on life...after all if I were stuck in a room/house 24/7 how long before I'd be another burden on society unable to work suffering depression etc etc it's hard enough being able to maintain an optimistic outlook when pain is a constant companion...</p> <p>3) Adaptation of living environment, access to travel requirements</p> <p>3) paying for help that 'normal' people don't even think about, taxi's for everyday travel because standing waiting for buses is not possible, having to plan every trip taking into account access to all areas yes there may be access but by using this access do you miss connections. Buying additional items to help with general every day chores, buying items/furniture specifically for people with disabilities...which are ALWAYS more expensive than 'normal' items. If like me you are lucky enough to have a Mobility car you still have to pay for any adaptations to said vehicle but it means i can carry on working, crutches/aides need replacing as they wear out all small things but they all mount up, and it may not be a monetary price that's paid it may be a mental one ...the ability to interact partake in life is essential!!</p>
ONLINE441	<p>1) Stigma, harassment, having invisible illness, increased costs, lack of confidence, loneliness, lack of money, low mood due to health complications, loss of employment, not likely to be employed due to health conditions and past sickness record, medications and their side effects, feeling unwell, restricted mobility, incontinence - worry about smell etc; anxiety attacks.</p> <p>2) All of it should stay the same - why fix it when it isn't broken?</p> <p>3) Heating - to keep warm if have musculo-skeletal problems. Washing and drying costs due to incontinence, clothing wears out faster Mobility aids ie scooters Sanitary wear Travel to appointments Costs of having someone with you whilst out Personal care costs Medication costs in some instances</p> <p>5) Yes - some should have an automatic entitlement due to health condition - some conditions are progressive and are going to get worse rather than better, and some are congenital problems and will always be like that. Why put disabled people through the extra stress of reapplying?</p> <p>8) No! There are increased costs in maintaining these aids ie scooters/chairs, never mind the horrific cost of them to start with.</p> <p>10) The GP or consultant and those in the primary care team if of course there are any. OT's, social workers, health visitors etc as it is now</p> <p>11) These are NOT healthcare professionals! They do not know you or your abilities and a meeting with these people and their 'computer' is very stressful for anyone with a disability.</p> <p>12) There should be reviews in cases where treatment could make the condition better, but there also should be some that are entitled to life awards due to their condition</p> <p>?) For myself DLA has been vital in accessing a DFG for a wet room. It is fine as it is - maybe more information for some who may not be aware could be</p>

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	<p>included in literature sent out with DLA packs            ?) Link to Chapter 4 not working .....            ?) Not sure there is anything else it could be combined with as disability benefits cover a huge spectrum of ages and abilities            ??) They either buy their own, often leaving them short of money for other things, or apply for grants eg Disabled facilities Grant to fund adaptations.            ?) Where else would these other benefits and services come from??</p>
ONLINE442	<p>1) Ignorance.</p> <p>Financial resource not only for state run services put for businesses in terms of employment and services they provide which is always geared towards "normal" people</p> <p>This government has also targeted these vulnerable people in all of the cuts which is now starting to affect them</p> <p>2) Why does it need reform? Who has said it needs reform - the people receiving it? This will just be a way of cutting benefits for people. We all know that however it is communicated we will end up worse off</p> <p>3) I look after a disabled a child. The main costs are only having 1 income instead of the 2 we used to have. Sometimes we both need to attend appointments which results in the working parent using holidays or time off unpaid. Car parking charges. Extra cost on utilities such as water and electric due to additional washing. Nappies for an 8 year old. Extra bedding and clothes.</p> <p>4) It is perfectly understandable at the moment</p> <p>5) A combination of both</p> <p>8) If you ignore those that the person might be eligible for then you are not doing the best for that person. Each person should know what they are entitled to and get it.</p> <p>9) The current form is too complicated</p> <p>10) all professional involved in care should contribute</p> <p>11) This will delay the process even further</p> <p>12) There are obviously some disabilities where circumstances will never change so reviewing it is just causing unnecessary work for carers. Criteria should be determined for different types of disabilities</p> <p>13) A letter once a year reminding them</p> <p>14) The process who to contact</p>
ONLINE443	<p>1) There are clearly a wide range of barriers which will vary in type and intensity according to each person's disability. It is important to recognise from the outset that it is not administratively practical to categorise the effect of disability on an individual into neat pigeon holes, and it is therefore welcome that the proposals are to retain payments which individuals can use as they require to meet their own individual needs.</p> <p>Access clearly involves physical issues and it is easy to see that many disabilities will give rise to problems in mobility. Often some mobility is possible, particularly with aids, but barriers arise in respect of physical features, accessible parking and the need for assistance from a carer. While legislation (Equality Act) provides rights and remedies in respect of the latter, there is little support for people to enforce those rights.</p> <p>Less well understood are the many 'invisible' disabilities. Mental Health conditions are by far the most numerous of these, and these are notoriously badly addressed both in equalities legislation and in the current DLA provisions. I do not have the expertise to set out in detail the many barriers which mental health puts in the way of participation in society, but it is an area which any reforms should address in depth to improve the ability of those with mental health conditions to participate and lead full and active lives.</p> <p>Further, there are many conditions, for example neurological conditions, which do not have such obvious external manifestations as physical or sensory disabilities, but which create similar barriers to participation in that, without assistance and aids, mobility, communication and social interaction can be extremely difficult. People with such disabilities face the same barriers as those with physical disability, but with the added problem that it is much less obvious that they need assistance. As an example, a person with neuropathic pain may be physically able to walk but the effect of walking may be to intensify the pain so considerably that they cannot do so for any length of time or, having done so, are in too much pain to participate in any sort of social interaction. Again, such conditions are not well recognised in current DLA provisions. Any reform should ensure</p>

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	<p>that support is available for people with such conditions.</p> <p>While the general approach to reform as set out in the consultation is welcome, it is clear that if the approach is genuine then there must be a widening in the criteria for the new benefit to allow support for a wider category of disabled people than is allowed under the current DLA system. This too is to be welcomed, but it is a serious concern that the political rhetoric accompanying this reform process identifies a potential reduction of 20% in the number of disabled people who will be entitled to the new benefit. This in turn must raise considerable concern that the fine words of the consultation document are merely a smokescreen to cover the political aim of reducing public spending on disabled people.</p>
ONLINE444	<p>1) Questions one and three of the consultation ask for information about the barriers and disability costs that disabled people face. If the government does not have this information what evidence base has it used to inform its proposals to replace DLA with PIP? If it is relying on the consultation for this evidence what steps has it taken to ensure that a cross section of the disabled population respond to it? Given the government's oft stated commitment to promoting the independence of disabled people, I am alarmed that it appears to be attempting major reform to one of the best ways of doing just that without sufficient research evidence.</p> <p>2) There is much about DLA that should remain the same. It should be non means tested, payable on the basis of self assessed need regardless of family situation or employment status. Yes, the current claim system is intrusive and lengthy. It contrasts sharply with the single page application that I complete when I claimed Mobility Allowance, the forerunner of DLA, in the late 70s. But the lengthy one represents progress. It reflects the very real complexity and diversity of mobility and care needs. It enables a modicum of self assessment, recognising that often it is the disabled person or those who know the disabled person most intimately that has the best understanding of their mobility and care needs.</p> <p>3) My concerns about question 3 are the same as with question 1: the government should systematically gather evidence about the extra costs of disability before it embarks on major reform.</p> <p>But here's a flavour of my disability related costs:-</p> <ul style="list-style-type: none"> <li>€¢ Having to pay for carpets to be regularly cleaned because I often spill things</li> <li>€¢ Having to pay transport and accommodation for my PA when I go away on holiday or business, costs not covered by my care packages</li> <li>€¢ Having to pay for my PAs pay each time I travel by bus</li> <li>€¢ Having to pay £60 for a wheelchair accessible taxi for a 10 minute journey to and from the station when I visit my aging parents. (If I want to go on Christmas or Boxing day there's a £150 minimum charge).</li> <li>€¢ Having to buy incontinence pads for the 30 €" 35 times when my catheter gets blocked or I have a stomach up and cannot time my need to use the toilet with when my PA visits. The District Nurses will not supply pads to those with a permanent catheter.</li> <li>€¢ £4800 for my power chair which I use all day everyday</li> <li>€¢ Having to pay over £250 for a computer joystick because I cannot use a standard mouse/touchpad. I'm on my 3rd joystick because when I drop them, they break. And the same is true of the keyboards I use. One company offered to arrange for one to be made especially for me of stainless steel. At £400 plus, it was out of my price range. Yet without computer, I could not do my job or manage my personal affairs.</li> </ul> <p>I really could go on and on. But if, as I sincerely hope, the government wants to base major policy change on evidence, read Counting the Costs, a research report by the think tank Demos, and commissioned by Scope. It can be downloaded for free at <a href="http://www.demos.co.uk/files/Counting_the_Cost_-_web.pdf?1292598960">http://www.demos.co.uk/files/Counting_the_Cost_-_web.pdf?1292598960</a>. This demonstrates that there is no simple relation between levels of functional needs and disability costs: so ensuring those with the greatest needs are awarded the highest payments may lead to inequities.</p> <p>The goal of ensuring that PIP is targeted at those with the greatest need sounds laudable. But how can one judge that a claimant who cannot walk more than 25 yards without resting to catch his breath is in greater need than someone who can ride a bike but has 5-7 fits a week some of which leave him so dazed that he crosses busy roads without looking? How can one judge if someone who is physically reliant upon others to get up in the morning has greater need than someone who cannot get up due to depression? If none of these</p>

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	<p>people have the highest needs, they still incur extra costs. If the state does not contribute towards these costs, people may not be able to get themselves in a position where they can look for work of they might be forced to access other services.</p> <p>4) Making PIP easy to understand and administer may come at the expense of flexibility and making an adequate contribution to disability costs. More importantly, the advantage of having two levels of payment depends upon the rate at which is paid and the eligibility criteria. Without this information, this question is impossible to answer.</p> <p>5) Assessment and reviews are costly to administer for both the state and claimant. In many instances diagnosis is not a good indicator of need. However, in some case it is so why not have a system which takes account of this, thereby reducing costs all round. For example, someone with quadriplegia following a spinal injury is going to have a high level of needs so why make then undergo a lengthy assessment. For many conditions there is good medical evidence that its impact is not going to change after it is stabilised and/or the person has undergone rehabilitation. So why the need for regular reviews as long as there is medical proof of diagnosis?</p>
ONLINE445	<p>5) There is an anomaly concerning DLA and state pension. Those approaching retirement need only convince the doctor that the 'bad back' or 'difficulty walking' warrants DLA and they have effectively doubled their state pension or secured a 'motability' new car for the rest of their life. We must of course help the genuinely needy but many in receipt of DLA are quite well off with company pensions, investment income, etc., and just regard the 'free' car as a bonus. The answer is to means test DLA for those in receipt of state pension.</p>
ONLINE446	<p>1) Prejudice. The general population need to be educated more about disability and the effects that illnesses can have on peoples lives. Mental health problems and hidden disabilities especially.</p> <p>Some employers still assume that people with underlying health problems will be taking time off work on a regular basis when in fact many people with conditions can actually be more determined to work through their problems and less likely to take time off for common complaints such as a cold or headache.</p> <p>2) Personally I think the benefit has a great purpose and should stay as it is. We simply need to get back to what it was intended for, rather than the watered down version of what we have now. I don't feel that medical examinations are neccessarily the answer in most cases, but evidence in other forms should be the norm, such as care plans, information from GP's, hospital Dr's and Specialist Nurses.</p> <p>3) Travel and parking costs - especially when attending hospital appointments etc. Prescription costs - I have to take medication everyday to basically keep me alive and healthy, but my condition does not fall under the exemption list. Monthly costs of prescriptions can be upto £60. Adapataions - From changes to homes and care aids to the cost of buying prepared food due to being unable to cook for themselves.</p> <p>4) Personally I think the benefit should remain the same with 3 levels for the care component. The low rate is great for people who simply have problems with their hands and need help to prepare a meal for themselves but are otherwise able to self care. 2 rates of care will either mean that these people are disallowed the benefit and will not get the help they need or be awarded the same amount as someone who needs help right through the day with care.</p> <p>5) The only conditions which should mean automatic entitlement is in the case of terminal illness. A double leg amputee with good aids is able to lead a relatively normal life in some cases. The effect of the condition on the individual should be the focus of the benefit.</p> <p>6) Transport is a major issue. A lot of disabled people have difficulty using public transport and the use of a car is vital to them. The ability to care for yourself is also huge, things like toileting, washing and dressing, cooking and cleaning.</p> <p>7) Medical evidence and advice. Also majority of the time should mean majority of the time. Somebody who can manage for 3 or 4 days of the week should not receive as high a benefit payment as someone who may only manage for 1 day a week on their own.</p> <p>8) No. People should not be penalised for having the funds to pay for their own aids and adaptations. That is a bit like saying that because you have savings and can buy a stair lift, you won't get any benefit when someone who has never worked and has no savings will</p>

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	<p>get the benefit simply because they have no savings and cannot buy a stair lift! Seems very unfair.</p> <p>The benefit should be paid on the basis of what help a person needs, not what help their receive.</p> <p>9) The claim form is fine as it is I think. The tick boxes make it easier to complete than the odd style form.</p> <p>The part which makes the benefit complicated is the date of entitlement. The 6 week date boxes should go, instead, simply backdate the benefit by 2 weeks from the date of receipt for everybody.</p> <p>More publicity about the benefit is needed. Many people say that they did not know about it and claim years after their needs actually begin.</p> <p>10) Medical evidence in the form of GP statements, hospital reports and letters, information from specialist nurses and medical examinations if no evidence is available from elsewhere. The carer and disabled person can also provide information about how the condition effects them everyday, something which Dr's don't always know as they only see the person for a few mins at each appointment. Care plans are also very useful along with reports from schools for children.</p> <p>11) Face to face meetings may not always be appropriate in mental health cases. Examinations can feel intrusive to some people and they should only be done if really necessary.</p> <p>Access to medical examination centres may be difficult for many customers with transport issues.</p>
ONLINE447	<p>1) Money, mobility,transport,stigma,social acceptance,understanding,tolerance,the disabled person's own physical,mental and communication problems plus his/her perception of his/her place in society.</p> <p>2) Three care components are essential because many people fall midway between high and low rate care, and will lose out under the new system.</p> <p>3) Care,transport,heating,medical treatment/drugs,the cost of activities recommended by their medical professional for their physical and mental well-being,e.g. 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 Carers Allowance.</p> <p>If I worked full-time I would not only lose my Carers Allowance, but would need to pay for a full-time carer, leaving us no better-off. My husband whom I care for cannot work.</p> <p>4) (a) No, it is designed specifically to reduce or remove the benefit. (b)People in receipt of the Medium Rate Care component, such as my husband, would be forced onto the low rate or lose all their benefit. I would therefore lose my Carers Allowance as well.</p> <p>5) If a person is diagnosed with a permanent disability he/she should get DLA, but common sense and compassion should apply. Some severe disabilities should automatically qualify, but I accept the requirement 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 for a second time how miserable your life is to be given a modest amount of benefit? Existing DLA recipients should be left alone, and PIP applied to new claimants only.</p> <p>6) (a) By awarding them the highest components of DLA/PIP, 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.</p> <p>7) The assessor must have a good understanding of the claimant's condition and listen to the claimant, carer, and their GP/consultant. Before my husband was awarded DLA I received a telephone call from the assessor to seek clarification of his problems and needs.</p> <p>8) Of course it should take account of aids and adaptations, but this should not be used as an excuse to reduce their mobility component. 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,</p>

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	<p>but merely help and support from their carer?</p> <p>9) (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.</p> <p>10) Evidence from the claimant,the carer, and medical reports.</p> <p>My husband has been taking part in research studies into his condition for a number of years, and would hardly be doing this if there was nothing wrong with him.</p> <p>11) (a) Extreme anxiety and difficulties for the inarticulate, people with learning difficulties and mental health problems(especially those on the autistic spectrum), and those whose conditions vary from day to day. This is government-endorsed bullying of vulnerable people.</p> <p>(b)This should not be necessary if there is sufficient evidence to confirm the impact of the disabilities.</p> <p>12) (a)This review is surely illegal as it is contrary to people's basic human rights. No review is necessary for people like my husband on the autistic spectrum, a permanent disability. This is insulting.</p> <p>(b)If people do not have a permanent condition, they should surely be on another type of benefit(s).</p> <p>13) If you have a permanent condition, why should you have to report any changes, unless your condition is deteriorating, and you require more help?</p> <p>?) (a) With their DLA</p> <p>(b) No - it should be a GP referral to Occupational Health or Social Services to assess you and provide for your needs. ?) Extreme anxiety, depression, poverty and possible suicide. We are supposed to be a civilized, caring society.</p> <p>Because of our low income, our DLA and CA are vital. ?) It has been crucial in enabling me to obtain Carers Allowance, in order to have a semblance of a "normal" life. It has also given us free loft insulation, enabled my husband to buy a Disabled Adult Railcard, and allows me to accompany him to the swimming pool free of charge. ?) Leave the system as it is, as being disabled is not necessarily the same as being unfit to work, although it might be.</p> <p>?) People can get all the help they need from their GP, Citizen's Advice, or charities that deal with their disabilities.</p> <p>Any system that is a catch-all umbrella can never be specific to a particular person. It is naive to assume it ever would be. ?) The question is irrelevant. ?) There is more structured care for children once they are diagnosed, but therein lies the problem. ?) This is fine, but needs to be discussed with the claimant, carer and the GP. ?) You have no idea how stressful, worrying, insulting and humiliating the proposals are.</p> <p>Anyone with a diagnosed disability has already endured numerous tests or consultations, and usually found it difficult to get DLA in the first place.</p> <p>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.</p> <p>The fear that my husband's DLA may be withdrawn can only exacerbate his condition.</p> <p>We use our benefits not only to meet extra expenditure resulting from my husband's condition, but also to help meet everyday living costs and bills including Council Tax.</p>

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	<p>Our only other income is my husband's small ill-health occupational pension, granted on the basis that he cannot work. Although he applied for Incapacity Benefit and passed the medical assessment in 1994 (ie was declared unfit to work) he never received this benefit owing to a lack of National Insurance contributions.</p> <p>The government needs to recognize that permanent disabilities affect people's earnings power and income, and that they depend on DLA etc to get by.</p>
ONLINE448	<p>5) Autism should be an automatic entitlement. the very nature ( it is a lifelong disability) and unpredictability of the condition makes the claim process so difficult. It can take years (7 in our case) to be successful in gaining an autistic child the help they so deserve through DLA. Also with the communication difficulties present in Autism as a child transitions to an adult and is expected to claim for themselves this could easily leave them without vital support.</p>
ONLINE449	<p>1) prejudice from employers and employees</p> <p>lack of suitable jobs</p> <p>a lot of disabled would like to work but would need a lot of support in the work place</p> <p>3) Public transport if they cannot drive. Heating, if they are not able to work then during winter months they need to keep warm. Services of a carer if they have no family to help.</p> <p>5) both - there should be an automatic entitlement with some conditions but then some individuals needs may be higher than others and will need assessing, just because someone has a condition it will vary from person to person</p> <p>5) BOTH. the varying health conditions must be assessed by experts in that field, one person's hidden disability varies differently from another. Someone with Aspergers must be given an automatic entitlement and then they need to be assessed as to how much to give.</p> <p>11) the healthcare professional must be an expert in the field of the person's disability</p> <p>12) yes there should be different types of review, a physically disabled person will have different needs to a person with a hidden disability</p>
ONLINE450	<p>1) Lack of understanding and insensitivity from those in Government, and some in Society. In this consultation there seems to be a complete lack of real understanding of the complex difficulties there are, for those who are disabled who will never be able to work, where it would be absolutely impossible for them to have an independant life. People are very, very, intolerant of those who are different. Many disabled people are invisible, especially those who are different in their behaviour due to brain differences, they are rejected by some. The awful looks and stares are intolerable due to a disabled persons, perceived different behaviour.</p> <p>I feel that Carers of Disabled Children have a particularly difficult time, not helped by the state, especially when it would appear by suggestions that children should receive less DLA or help, because they are cared for by schools some of the time, this just illustrates how little understanding there is, what of the school holidays where a parent or carer cannot work, because there is no childcare available, or if one was lucky, you might get four days in a summer holiday. Very often one Parent, carer will be out of work because of the caring role, receiving nothing more than Carers allowance. If the Carers lives are made more difficult than they already are, then the Childs life will be affected as a consequence. Carers are often living on a knife edge of just about being able to cope, the lack of compassion, understanding and help is a barrier to the disabled child, the family of the child existing in society. Carers life chances are very much altered, which of course impacts on who is being cared for particularly a child.</p> <p>2) Just leave it all alone. Society and disabled peoples needs have not changed that much since the 1990's, the awful deficit and the Governments need to slash and burn is what has changed. DLA is of course initially complicated, because there are so many different levels of need and disability. The recognition that levels of disability vary is very important. It should still be that if information is needed to find out about a persons disability then their specialist, Paediatrician should be consulted in the case of a child, the persons needs should not be decided by someone who has no knowledge or history of the person.</p> <p>3) a person may not be able to use public transport, so needs the mobility transport. Indeed mobility is also affected by brain impairment. Washing costs, electricity etc can be</p>

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	<p>considerable due to the disability, incidents of soiling greater. The extra costs that can be incurred by the affect of caring for a disabled Child or adult is not remotely met by DLA or Carers allowance. Perhaps this fact should be considered, for example if a Carer were to relinquish care of a disabled Child, the cost to the State in care would be approx 200,000. Heating costs can be very different, due to physical needs, eating differences, textural issues making it difficult in clothing someone. Shoes being much more expensive, parking costs being greater, having to go to hospitals for appointments etc. Holiday costs etc.</p> <p>In the case of a Carer of a disabled Child, the costs are even more immense, careers will have stalled, standards of living will be reduced as a consequence.</p> <p>4) this is rather hard to answer because the perceived activities etc has not been explained, it does not really seem much different to the DLA, and if any thing would be just as confusing or unfair to some.</p> <p>5) yes I think it should remain the same, and probably it should be expanded to automatically be given to those who are mentally incapacitated, in a severe fashion, the facts of these can be checked by contacting the medical professionals as before.</p> <p>there is a great danger with some individuals who are very stoic, they pretend they are managing better than they are, they suffer and dont complain, I fear some will end up losing out because of this diminishing of their condition.</p> <p>6) from the beginning basics, dressing, washing, eating, understanding of others, sense and understanding of dangers, ie. can the individual be safety aware, or are they exceedingly vulnerable, for example have no road sense, or "stranger danger" awareness.</p> <p>7) simply an understanding of someones condition, with supportive information or confirmation from a medical specialist should be sufficient. many conditions will fluctuate in their severity, and that fact should be allowed for to begin with. Perhaps a recognition that pushing people when they have a disability, if they are at a better part of their condition could actually cause their condition to worsen. Stress is not helpful to anyone.</p> <p>8) no it shouldnt, there are always times that aids very often are no longer of great help, wheelchair access is not available everywhere, a prosthetic limb may become excruciatingly painful on some occasions, or after a period of walking</p> <p>9) less repetition, just clearer language would help.</p> <p>10) if a person already has a health care professional involved in their care is it not more sensible that they give the evidence, be they a Paediatrician, a consultant, Occupational therapist Social worker etc.</p> <p>11) to be frank the thought of it fills me with horror! How expensive is this excercise going to be if this person is to be medically qualified enough to understand such complexities of issues faced by a disabled person. I think it could be exceedinly distressing for vulnerable people, the notion of a queue of disabled people seeing whether they are disabled enough is a very unpleasant thought. I think it is a very costly proposal, I think it would be cheaper to have as it is, a form, and evidence given by involved health care professional.</p> <p>12) if someone is irreversably disabled, they remain thus, once a year review is too much, once every three to five years would cost less, and be less intrusive.</p> <p>13) just have clear documentation.</p> <p>14) this is slightly ludicrous, in theory the person already has health care professionals involved, who are much better placed to be helpful, I would hope. It may be if the person is near the beginning of coping with a disability, if they re newly disabled then some pointers or help might be useful.</p> <p>15) I am sorry but this shows a complete lack of sensiitivity, it reads very unpleasantly indeed, these aren't people whose disabilities are going to be improved in the same way as someone who is unemployed might be helped by some work expertise course....if someone is disabled, they are disabled.</p> <p>16) yes there should be some access to a fund.</p> <p>17) the impact on a Childs family, that a parent may be unable to work at all due to caring. the increased costs of care, washing clothes, bedding etc. protection and safety issues. the having to visit specialists. because a child is at a special needs school does not mean that the disability costs should be reduced, the parent or carer is still dealing with caring issues when the child is not there, doing washing, cleaning etc. life chances are very much altered for parents of disabled children, very often</p>

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ONLINE451	<p>1) Engagement is the caterpillar: empowerment is the chrysalis: autonomy the butterfly. ©Linda Jane McLean</p> <p>John Major understood this.</p> <p>The following episode is recounted to underline the simplicity of the problem: and the difficulty that there is in perceiving it.</p> <p>PRACTICAL CONSEQUENCES - (true account)</p> <p>Born in the late forties in Hong Kong, █████ developed polio before he was a year old. His mother became a widow at about the same time, so she returned to Scotland to give her only child the chance of a good education. There █████ grew to be a bright and likeable youngster, although he had to use a wheelchair.</p> <p>Trying to access Primary education was difficult - and the mother had to fight to get him an "ordinary" schooling.</p> <p>Secondary school was even harder. But together they fought . He was intelligent and articulate, with a keen sense of humour and plenty of friends, and the effort was successful. By the end of his schooling he passed all his Highers and was accepted to by the University to study Law.</p> <p>University was an older building, with no lift to the Library. █████ had to wait until a fellow student was going up - and likewise coming down - so he could get a piggy back. Not knowing when these events would happen had a knock-on effect - he could never even tell his mother when he would be home for tea.</p> <p>However, with his Degree gained, he found a job in a lawyers practice. All the fighting, all the effort, had been worthwhile.</p> <p>After a few years, he expected to become a Partner.</p> <p>However, when his time came, the firm merely said: "It would not look good" promoting someone in a wheelchair.</p> <p>The penny dropped " the light-bulb was lit "full comprehension dawned.</p> <p>He could work as hard as he wanted - he could give everything he had to conform to society's rules: he could offer his blood, sweat and tears. He knew that he had put in more effort to attain his position than anyone in the firm. None of that was sufficient, however, if, at the end of the day, the attitude of Society disabled him.</p> <p>In total dejection and humiliation he resigned the post that he had fought so hard to gain.</p> <p>But an important lesson had been learned: if people could further disable him, by attitude alone, he would show them what it felt like.</p> <p>Never again did he treat an able-bodied person as an equal.</p> <p>xxxx</p> <p>These attitudinal barriers, which are as real today as then, and which employers know are not effectively legislated against, are fully exploited.</p> <p>I could give numerous examples.</p> <p>I could write a book.</p> <p>But those who are able do not see - are unwilling to see - the tremendous effort made by each individual to be what Society demands.</p>

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	<p>Politicians, it would appear, when it comes to disability believe the press -that the majority are scroungers.</p> <p>Disabled people are not deceived by the words "newer" or "Fairer".</p> <p>There is nothing fair in what is being proposed.</p> <p>Even if a disabled person managed to obtain work, they would now be unable to reach the premises due to this policy. If ILF is being withdrawn, nobody has a hope.</p> <p>Supposing - by some extraordinary miracle - , that getting out of bed and getting dressed is managed at the same time every day - time to go to work.</p> <p>Who is going to put on their coat if they manage to get transport arranged?  Who is going to take it off when they reach work?  Who is going to assist them at work?  Who is going to toilet them?  Who is going to put their coat on again?  Who is going to open the front door?  Who is going to take their coat off in the house?  These are the fine minutiae that people with a disability have to consider.</p> <p>You can say that others will help them - but when this is a daily requirement, others start to resent it. I have seen it. Nobody minds helping someone on a one off basis.</p> <p>The only answer to this question is a Personal Assistant - which empowers and enabled the person - but you appear to have set your face against the obvious answer.</p> <p>You want people to be dependent.</p> <p>1) Everyone, able-bodied included, require certain necessities. I submit that of the following six elements, if you remove even one, a degree of impairment will follow. HEALTH, EDUCATION, HOUSING, TRANSPORT, EMPLOYMENT AND SOMEONE TO CARE.</p> <p>Think for a moment how you would feel if you lost just one of the above elements. Sometimes a personal story may help you to see that you are aiming at the wrong target. Disabled people long to work. What prevents them is documented herein - and is a true story. All of the above elements are encompassed.</p> <p>The Invisible Climber  Born in abroad in the late forties, ██████ was destined never to see his father, who gave his life for his country in the latter stages of the Second World War. The next disaster that befell him, was that he contracted polio before he was a year old. His widowed mother returned to Scotland to give her only child the chance of a good education. There ██████ grew to be a bright and likeable youngster, although he had to use a wheelchair. Trying to access Primary education was difficult - and the mother had to fight to get him an "ordinary" schooling. But if accessing Primary Education was difficult, Secondary School was a battle royal.</p> <p>But together they fought . He was now intelligent and articulate, and had done well at primary school. He had a keen sense of humour and plenty of friends, and the effort was successful. By the end of his schooling he passed all his Highers and was accepted to by the University to study Law.</p> <p>University was an older building, with no lift to the Library. ██████, now used to such problems, had to wait until a fellow student was going up - and likewise coming down - so he could get a "piggy back". Not knowing when these events would happen had a knock-on effect - he could not inform his mother when he would be home for tea, for instance. However, with his Degree gained, driving test passed, he found a job in a lawyers practice. All the fighting, all the effort, had been worthwhile. He married a pretty graduate and they invested in a house. His career was on track.</p> <p>After a few years, he expected to become a Partner.</p> <p>However, when his time came, the firm merely said: €□ It wouldn't look good" having</p>

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	<p>someone in a wheelchair as a Partner.  The penny dropped €“ the light-bulb was lit €“full comprehension dawned.  He could work as hard as he wanted - he could give everything he had to conform to society's rules: he could offer his blood, sweat and tears. He knew that he had put in more effort to attain his position than anyone in the firm. None of that was sufficient, however, if, at the end of the day, the attitude of Society disabled him.  In total dejection and humiliation he resigned the post that he had fought for over twenty years to gain. █████ learnt that people could further disable him by attitude alone. He therefore determined to demonstrate how it felt.  Never again did he treat an able-bodied person as an equal. They were all completely unaware of the stupidity of their actions: their limited view of the capabilities of the €less able €□ caused untold hardship and waste. He was not unpleasant to able bodied people: he was always well-mannered and humorous €“ but slightly condescending. People were at a loss; they did not know how to react, being treated that way by a wheelchair user.  When someone thoughtlessly upset one of his disabled peers, he was heard to remark: €œOh, don t worry about what HE thinks. He s just an able-bodied person. You might as well try to teach a prawn to whistle as to try to make him understand. €□  █████</p> <p>This question demonstrates that basic lack of comprehension which █████ identified. Someone who understands the problems is required - and you will not find that anywhere apart from in the disabled world. Their knowledge is vast - it has to be.  They have hurdles, barriers and problems placed before them with monotonous regularity. No-one notices that every day a disabled person has a mountain to climb: that is why the title of the piece is "The Invisible Climber".  It is a superhuman effort that goes unseen, unrecognised and unrewarded.  2) Based on the previous answer,you may see that I believe Disabled Living Allowance has to compensate for far more than Care and Mobility.  It is essential to many people.  Consider someone who sustains a spinal injury suddenly. Not only has he lost his HEALTH, his EMPLOYMENT will be jeopardised, his HOUSING may be unsuitable,TRANSPORT will become a problem, and his wife/partner (SOMEONE TO CARE)may feel unable to cope.  Out of the six components, he has only education left. On that he must try to build a new life.  It requires help and encouragement, and as much support as possible.  From the summary,I see that someone in this state will be required to wait 6 months before PIP is awarded.  This will cause hardship and dependency: it is a false economy.  To create an Independent citizen, there needs to be a mechanism to get them up and motivated as quickly as possible. By delaying any payment for six months, you could also be increasing the time such a patient must spend in hospital - with the additional costs to the Health Service.</p> <p>3) Have you considered that if you were unable to get on a bus, unable to do your gardening, unable to do your housework, unable to redecorate - that you would be required to hire someone to do all the above? And how would you manage that on benefits?  It is not an inconsiderable amount that disabled people are out of pocket.  I was hearing of one disabled person yesterday, who had to apply for 546 jobs when he left University before he was successful. That is a lot of paper and stamps.  Paper and stamps that could not be afforded with your "new" system.</p> <p>3) Here I will consider the person with the genetic condition such as Muscular Dystrophy, but can apply to any wheelchair user.  CLOTHING  Special clothing, due to the change of body shape, is essential,and does not come cheaply. It has been necessary to have bespoke clothing made. "Off the peg" availability is frequently not possible.  Shoes may be an extra expense that people don't think about for those in wheelchairs.  This can be an extremely costly item if you have full D480sensation. They need to be warm - or fur lined - and tracing and ordering such items can be challenging as well as expensive.</p> <p>TRANSPORT  If not in an area where transport is provided cheaply, the costs are horrendous.</p>

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	<p>One lady I knew spent £40 to travel five miles by "special taxi". Some areas will not offer decreased rates if you are not resident. London was one example that I knew of: £60 was the fare ten years ago to travel five miles with an electric wheelchair.</p> <p><b>LEISURE AND RECREATION</b> Holidays are one of the few pleasures - but will cost on average three times that which an able bodied person will pay. This is because only the superior hotels cater for the severely disabled individual, and if you require carers, you will need to pay for their accommodation too.</p> <p><b>EDUCATIONAL EVENTS</b> Equally, if you want to attend conferences - the costs would make an able person seriously consider. But if there are issues to be raised, if their voice is to be heard, these are costs that disabled people must bear.</p> <p><b>HEATING</b> Heat is important, as it is impossible to generate energy through exercise, so heating bills are double the average. In addition, if going out, extras such as "heat pads" may be required. These costs must be borne by the individual. Then there is maintenance of equipment.</p> <p><b>EQUIPMENT COSTS</b> Once a wheelchair has reached a certain age, insurance will not cover it. We were left in a position where the wheelchair had been condemned by the NHS, but no replacement was forthcoming before the death of the client two YEARS later. (He had been waiting for a new chair for five years before that.) It is an expensive business being disabled, and if you are- as this gentleman was - unable to do anything physically it is a soul destroying existence.</p> <p><b>ADDED COSTS</b> Any piece of medical equipment that is needed has an extra nought added to the price. From hearing aids to non-slip mats - you pay a higher price every time.</p> <p><b>FURNISHINGS</b> The there are floor surfaces - the carpets must be hard wearing. Laminate flooring - although easy for propulsion - can be very cold, and cannot be used throughout a residence. When someone has a disability, the environment is extremely important - if you cannot do anything physically, you need a pleasant outlook. Maintaining that outlook, or garden, costs money when you are unable to do it yourself.</p> <p><b>MAINTENANCE</b> What most people consider doing themselves, is not possible for the disabled person. Maintaining your home costs more, if you cannot undertake small jobs.</p> <p><b>Independent Living \education</b> This gentleman pioneered Independent Living (before legislation) and was able to teach every day. This kept him intellectually stimulated, as well as creating a small cottage industry for the Community. He trained thirty girls who had been long term unemployed. This occurred daily until six weeks before his death. The girls all went on to better employment - his effort was recognised by the Queen, as she awarded him the MBE Everywhere you look, money is required.</p> <p>4) Personally, I feel that you save a considerable amount of money by going back to the "Registration" of disabled. This would be submitted by a GP for a condition that is long term, and without any known cure. You require a base line for disability, and then build on that, the more complex the needs become. There would be no need for ATOS assessments. It appears pointless issuing a medical certificate if someone can override this judgement with a "functionality assessment". Having been assessed, and examined inappropriately, it is infuriating to be told that this long term condition, which I have managed all my life, will get better within a year. It has all become much too complicated</p> <p>5) Some of these proposals I find quite disturbing. You are suggesting that payment ceases after 28 days in hospital, from my understanding. Let's turn that on it's head. Would you feel content to forfeit your salary after 28 days in hospital? If not, I would suggest that you lose this idea.</p>

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	<p>I have never understood why money for hospital stays is only taken from the poorest and most vulnerable.</p> <p>I have no objection to it being a rule - but if it is - everyone should pay.</p> <p>As it is, it is inequitable, and I wonder what the EHRC view would be?</p> <p>When I worked in the NHS, one of my Nurses was disciplined for collecting funds for Red Nose Day, because the NHS cannot ask patients for money.</p> <p>HOWEVER, THEY CAN TAKE IT.</p> <p>If someone with a disability goes into hospital, it is the one chance that there is to catch up financially - for a short while. Heating bills will be non-existent, and food is provided. It is a wafer-thin existence for many - with a simple thing like a Parking ticket throwing finances into disarray.</p> <p>I find it an anomaly that Prisoners are PAID £25.00 per week, AND receive food, shelter, access to computers, recreation and work. As a criminal, you are far better off than being disabled.</p> <p>By being disabled you are punished: no-one will employ you; it is difficult to find accommodation; you need to pay heating and food bills from a pittance; and you are labelled a scrounger. Those who have committed no crime are brutally treated.</p> <p>Would a Prisoner lose his Allowance in hospital? I don't know the answer to that.</p> <p>What I know, and have complained about for years, is that disabled, poor, elderly and those most in need are hit very badly. Anybody depending on the State for anything is punished.</p> <p>Meanwhile the wealthy enjoy the freedom of free treatment, because a mechanism has not been considered.</p> <p>It simply beggars belief.</p> <p>Can we not tackle the root of the problem rather than the symptom?</p> <p>Can we not see that by engaging and empowering our citizens, we will produce a more independent individual - able and willing to problem solve - and more likely to stand on his own feet.</p> <p>Can we not encourage, rather than condemn?</p> <p>Government needs to understand that the last thing on earth a disabled person wants or needs is to sit at home all day.</p> <p>But unless and until the employers understand what they are missing - until they are educated and enlightened - many do not have a choice.</p> <p>6) I believe that you need to create a model.</p> <p>People whose lives have been disrupted - who are no longer sure what they can and cannot do - need assistance to identify their strengths from a new position.</p> <p>They need someone to work with them to identify these strengths, and transform them from unable to able.</p> <p>7) Here I will mainly address the topic of aids and adaptations in assessment.</p> <p>This is my story.</p> <p>My severely disabled gentleman managed to get environmental controls installed, and they made his life simple. He could open and close curtains, had control over the front door opening and closing, (and therefore who came in and out). He could put on lights and use the phone with this technology.</p> <p>His OT did not understand why he needed control of the curtains - and he made his point quite forcibly:</p> <p>"When I wake up in the morning, I want to see what sort of day it is. I don't think it is fair to waken someone to open my curtains."</p> <p>However, he was told not to tell anyone of the provision, as everybody would want it!</p> <p>Towards the end of his life, he was hospitalised.</p> <p>Unable to shout and without the strength to press a buzzer, he was unable to attract attention.</p> <p>He was distraught, and informed me in astonishment:</p> <p>"I'm really quite disabled, you know!"</p> <p>So how much you encourage and empower people has a real and positive effect on their mental health. Once he felt that he could do nothing in hospital, it took many more staff to fill his days - I had to arrange rotas from 9a.m. -10p.m., as the Nurses were unhappy about his complex needs.</p> <p>Just another small example of how money, which was meant to be used in the Community required to be transferred to the Hospital setting.</p> <p>A good Occupational Therapist, who works with her patient and helps to educate as well as</p>

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	<p>provide, is worth their weight in gold. The person wants to learn - needs to learn - but very often does not understand the importance of a peer group.</p> <p>A more established body of Disabled People can guide the newcomer through a maze of confusion. By making it a club in Scotland, where we had specially adapted premises, serving lunches, coffee and having social evenings, it provided successful peer support and a place for learning and exchanging knowledge. Many looked upon as a life saver if they had nowhere to go during the day, and felt they were too young and able for a "Day Centre".</p> <p>It was an education for many - and it was such a pity that we lost it. There was huge potential - not only for assessment - but for assessment by one's peers, social inclusion, education and entertainment.</p> <p>And, of course, it is an innovative way of creating a role for people with disabilities. This is a process I call empowerment - this is the chrysalis. This is where autonomy is learned.</p> <p>It will take time and patience - but once understood and undergone, these people should be able to mentor and assess others, to achieve the maximum capacity for all of our citizens.</p> <p>In the meantime, a small model is required for Research purposes - to assess what works best - how people respond - what the problems are.</p> <p>8) It would be a complete wast of time not to consider such things in an assessment.</p> <p>9) The positive element about disability is that it teaches you about people and situations. The current forms are not fit for purpose, to the extent that I would question whether there was a requirement for them. I have found them to have a devastating effect emotionally - as difficulties I have are suddenly brought into full focus.</p> <p>The gentleman I worked with took at least a week to recover from filling one in, as he realised that there was nothing he could do - from feeding himself to holding a cup. It appeared a cruel and malicious exercise for someone who tried his best daily to cope with enormous physical difficulties.</p> <p>As I have previously suggested - find your base line: allow a GP to register someone as disabled according to the criteria, and a submission by the Consultant should be all that is required.</p> <p>However, if you want to persevere with forms, the one question I would ask is: "Do you feel disabled?" and then ask what made it so. People who are able, may find this difficult - and a much fuller impression may be gained if you ask for a description of their day.</p> <p>A personal account is always much more revealing than the tick box method. Try and do it yourself.</p> <p>I'm being serious.</p> <p>Try to fill in the form.</p> <p>I know people who will not clacause they find this degree of questioning too intrusive. So try it.</p> <p>Try writing down how you go to the toilet - in the full knowledge that other people will read it.</p> <p>There must be a way for people to explain other than ticking boxes.</p> <p>A "Storyteller" may be helpful. Not only could such a person collate and write pertinent information, but perhaps give an insight, which at the moment is lacking.</p> <p>Facts and figures seem to be what Government is based on; but you need more.</p> <p>You need evidence of where inclusion has failed;</p> <p>you need evidence of unsympathetic employers:</p> <p>you need to understand the problems which discourage many:</p> <p>you need to see, that when it comes to disability, the connection between housing, transport, health, employment is broken.</p> <p>The result is that disabled people spend their lives waiting.</p> <p>At the moment, only the symptoms are being tackled. When the root cause is identified, progress will have been made.</p> <p>But time and again, the offer of help to do this is refused.</p> <p>Tackling the symptoms is far more expensive, because the underlying malaise goes untreated and unseen.</p> <p>If there was decent quality of information at the beginning, there might not be such a rush to ATOS.</p> <p>Perhaps another disabled person could help to review. They are much more aware of and alert to people who want to rob the system. They don't want the system robbed because:</p>

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	<p>a) it gives them a bad name.</p> <p>b) it would make them worse off. utting money in, will I believe make us much richer in the end, rather than struggling along with a system that is broken.</p> <p>10) If you want a clear assessment of disability, it will be very expensive. It can only be achieved over a long period of time for some conditions. Other people appear very disabled, but given the right equipment and with sufficient support can achieve great things. You are seeking an answer to identify scroungers. As most disabled people do not fall into this category, you are aiming at the wrong target. MOST DISABLED PEOPLE WANT TO FEEL NEEDED AND INCLUDED, AND THAT IS FAR MORE IMPORTANT TO THEM THAN WHAT THEY AN 11) There are things to remember:</p> <p>There is no point in constantly reviewing a condition that is deteriorating. It causes great distress.</p> <p>For conditions that will not improve - such as Spinal Injury, Cerebral Palsy, I would suggest that the same rules apply. Nobody is going to get up and magically walk away if their spine is irreparably damaged.</p> <p>There are others that I can think of.</p> <p>None exclude employment.</p> <p>I knew someone who could not walk nor move his arms, but managed to use his voice for telephone sales.</p> <p>Such ingenuity is seldom broadcast - and it would help the morale of those less able if the stories were told.</p> <p>A face to face with "a healthcare professional" is a complete WASTE OF PUBLIC TIME AND MONEY.</p> <p>The diagnosis has already been given by the GP. Their word, and usually that of a Consultant, should be good enough "Functionality tests", as I understand it, override a sick note. So you can be sick, terminally ill, but be functioning.</p> <p>These tests do not measure motivation - nor do they measure realistically what can be expected. They are not fit for purpose, and are performed by a complete stranger.</p> <p>How well would someone know you after half an hour?</p> <p>That depends on whether you want to be known or not. Most people who must comply this charade, do not want to be known - they resent it greatly.</p> <p>Until you find a system that the public understand and agree with, I would only introduce face to face interviews with employers, to ascertain how many disabled people they employ. Make them come to you.</p> <p>Do not make allowances or try to help them in any practical way. Simply tell them that they must attend - or they will be fined heavily.</p> <p>That is a more likely solution to your problems, than aiming at the wrong target..</p> <p>12) Reviews of the person with a disability need not be repeated. If it has been established that they have an impairment which is not going to improve, what is the point of reviewing it?</p> <p>Reviews are threatening to the individual, and extremely stressful.</p> <p>That is the down side.</p> <p>On the positive side, I know of no evidence to say that reviews are effective.</p> <p>I would far rather that the citizen was empowered and confident to approach the job market - and not feel endangered by attitude or bullying.</p> <p>Having lived in a large Community of people with disabilities, I have been counting off all those in my street who did not work.</p> <p>There were only two, and these were pensioners.</p> <p>Of the rest - paraplegics and tetraplegics - blind and MS, all went out every morning to work. It would not have occurred to them to do otherwise. You cannot live on benefits - you have no standard of life.</p>

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	<p>Many had to access their office by the mail delivery entrance.</p> <p>As for different types of review - how costly and cumbersome do you want to make it? 13) The only way that you will obtain that kind of compliance is when you treat people as important - and not as numbers, scroungers or con men.</p> <p>I see the headlines in today's Telegraph,5/2/11, state David Cameron is asking that Muslims accept British standards of "freedom and equality".</p> <p>Now, I dare you to ask any disabled person if they feel free and equal.</p> <p>Yesterday I was at a Welfare Reform lecture and this statement was made:</p> <p>"They say you're never oppressed until you feel oppressed.</p> <p>Many of my contemporaries felt oppressed. Segregated in their family home, unable to get out and do the things they wanted.....even worse were those in residential homes. They couldn't even decide what to eat each day of the week. The gruel was just plonked down in front of them whether they wanted it or not" (██████)</p> <p>The current system is grossly unfair, difficult to access and slow to respond. It is uncomfortable, and if you need to use it, you must be prepared to surrender all confidential information. It is so sluggish when money is desperately needed, that no-one is going to jeopardise their income again.</p> <p>They all knew how hard they had to fight to be get into the system. It takes every strip of dignity you possess. Anyone would require to be seriously deranged before admitting that circumstances had changed.</p> <p>I HAVE BEEN ADVISED TO LIE BY THE JOBCENTRE. This is very confusing.</p> <p>If expenses were allowed (after all, those who represent us receive expenses on top of their CONSIDERABLE salary )life would be much easier. A voluntary position may lead to full time employment(given a working benefits system): it will certainly improve a CV.</p> <p>If there were not one law for the employed and one for the unemployed, it would be rather fairer.</p> <p>Consider: if expenses were allowed,there would be a possibility of the disabled person to taking up voluntary work. To penalise him/her - to force them to submit every expense - simply impedes what could be achieved.</p> <p>So what happened to David Cameron's "freedom and equality"?</p> <p>Or is that just in Animal Farm, where some are more equal than others?</p> <p>The person who makes up the rules has to understand what it is like using the system. I suggest that you could do worse than employ a person with a disability. OR CANNOT DO. They know the answer to that only too well - and it has a detrimental effect, this continual demand for assessment.</p> <p>This is where Society fails them - by not providing the means to succeed.. What must be understood is that everybody needs to feel needed. At the moment, disabled people feel that they are a burden - and it is a very depressing place to be.</p> <p>They can shine like stars, given the opportunity. s and until the employers understand what they are missing - until they are educated and enlightened - many do not have a choice.</p>
ONLINE452	<p>1) Their disabilities are not considered or accommodated by society. They cannot lead independent, full and active lives because their disability prevents them from becoming independent and because the means to achieve this is closed off to them.</p>

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	<p>3) For people with autism and associated conditions, the main extra costs are replacing soiled and/or chewed bedding; soiled carpets; damage to furniture and interiors, e.g. frequent need to replace toilet seats &amp; replace delicate equipment like headphones; therapeutic aids, treatment &amp; equipment; costs associated with special dietary needs; costs associated with needed dietary supplements; spoiled foodstuffs resulting from eating disorder; costs of petrol transporting person to specialist clubs and resources often a long distance from home; cost of personal care not supplied by Social Services; cost of accessing unsubsidised specialist resources/clubs. The list goes on.</p> <p>4) The change will cause difficulties because it is removing a whole category from the middle.</p> <p>5) There should be automatic entitlement for some conditions, without question.</p>
ONLINE453	<p>1) A Government hell bent on reforming DLA. Why ? Because they would rather focus on taking money from the needy, than collecting £120 million of unpaid tax from thier millionaire chums.</p> <p>2) Everything - it works and helps people, many of whom are in work already.</p> <p>3) Paying for the things you can't do for themselves eg DIY, plumbers, painters, car maintenance etc.</p> <p>4) Why change it, it ain't broke ? Get your rich banker chums to pay the money back they lost, Mr Cameron instead of stealing it from public servants and the disadvantaged.</p> <p>5) Look, i'm paralysed in one hand. It ain't going to jump back into life now, after 23 years, is it ? So, two DLA reviews and Appeals later, I get a Life Award. Thanks. But now we have to go through the whole chardade again. It beggars belief... all to plug a hole left by greedy bankers.</p> <p>6) You could start by targeting those not in work. Having worked with a disability for 23 years, get off my case at least!</p> <p>7) Like what, a miracle cure for the paralysed ?? The limbless growing a new limb ? I can't open a tin now, nor could I 23 years ago. What a clueless question....</p> <p>8) You mean the ones we bought with the DLA and paid 20% VAT on ? God Almighty, of course it shouldn't. ' Oh look, he has some adaptations... life must be easier, stop his benefit now.. '</p> <p>9) See above - i've been awarded a Life Award twice, assessed twice, reviewed twice, Appealed twice, seen Doctors twice. Which part of more positive could putting me through that again would that be then ??</p> <p>10) The lifeless limb that hangs of my shoulder would be a starter for ten..." Any sign of life in yet ? er no ...</p>
ONLINE454	<p>1) Every day a disabled person is faced with difficult challenges out of their control to fit in and take on the world around them. Society does not accept and will not ajust to take in to account peoples needs on a daily basis. My son has autism and peoples lack of understanding and negative responce towards him makes each and every day a struggle.</p> <p>2) The carers allowance needs to be considered in all of this, as this is often the greatest impact in a disabled persons life.</p> <p>3) Disabled people experience extra costs in many differnet ways, visits to the hospital more frequently, changes of clothes,bed clothes etc, support with coping on a day to day basis with their difficulties,different types of equipment needed to support different disabilities and theroxy/treatment that may be required on a daily basis.</p> <p>4) As long as the system is introduced fairly and managed well and people are kept informed of the changes. I don't think it matters how it is administred. It will be the questions and type of assessment process that needs to be well structures so that every individual cases is assessed correctly.</p> <p>5) Some conditions should have an automatic entitlement as people suffer long term with conditions, but still work hard to maintain as much of a normal life as possible.</p> <p>6) This would need to be looked at on almost an individual basis. In these situations the care element is important.</p> <p>7) variable and fluctating conditions should be taken in to account, but they would possibly need to be monitored closely. Most people with these types of illnesses still have good days and bad days and work hard to continue with as much of a normal life as they possibly can. A general realistic payment could be considered.</p> <p>8) Yes any aids and adaptations should be considered as that person has to use them to be able to carry out what ever tasks they can.</p> <p>17) When it comes to assessing children you need to look at the whole picture. The</p>

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	<p>provision provided for my son (who has autism) at school is not sufficient to show any great improvements in his learning. Little support is given with his anger management for example. I spent a lot of time working with my son both to develop his learning and understanding of the world around him, and there are several areas that I have great concerns about for the future as he grows up, but the services we should be getting help from are over stretch and so you are left to sort it out the best way you can.</p>
<p>ONLINE455</p>	<p>4) I think that the seeming simplification offered by having two levels of benefit rather than three will be far outweighed by the number of people who will not receive the appropriate level of support due to falling in the middle (or slightly lower than middle) half of the spectrum of need and hence receiving much less support than previously. It is not the three levels of benefit which seem to me to be the problem, but rather the complicated method of claiming it.</p> <p>I am concerned about having only two rates for each component, as I fear that those who currently get the middle and lower rates of the care component of DLA will be disadvantaged. It is difficult to categorise people into only two categories as there will be a wide spectrum of needs rather than two distinct groups with a distinct boundary.</p> <p>Although it seems more complicated on the surface, a sliding scale of benefit, based on actual need rather than on a seemingly arbitrary cut off would be more equitable as this would provide a level of assistance more closely related to the person's level of disability. This could also be relatively easy to understand as it would directly relate to the person's level of disability.</p> <p>?) DLA important in being able to claim other services. It is the main way of recognising a person as disabled and hence is used to access such services as:</p> <ul style="list-style-type: none"> <li>-access to 'access to work' funds</li> <li>-recognition of disability in workplace</li> <li>-help with transport (disabled rail card, bus passes etc)</li> <li>-disability help and concessions when going out, e.g. ability to access wheelchairs, help from companions,</li> <li>-radar keys for access to disabled loos</li> </ul> <p>If the new benefit is withdrawn from those with a disability but who have developed coping strategies or who are considered to have a lesser level of disability, their ability to function in society will be severely impaired due to the loss of these services in addition to the benefit. For example, the lack of access to 'access to work' funds will mean that the person will be unlikely to be able to get recognition for their condition from their employer and to be able to get reasonable adjustments made such as flexible working, help with transport, computing equipment etc. I am deeply concerned about this</p>
<p>ONLINE456</p>	<ol style="list-style-type: none"> <li>1) Disabling mental health problems, genetic conditions, injury and disease; lack of funds; lack of personal support; societies attitudes; unsuitable physical facilities, difficulty in obtaining specialist aids and equipment like communication aids.</li> <li>2) assessment of care and mobility needs as two separate factors</li> <li>3) transport costs, personal support costs, and equipment costs.</li> <li>5) Long term conditions like schizophrenia and Downs should have an automatic entitlement to a lower rate with application to be made for higher rate.</li> <li>6) Assessment by health professionals. Sleeping through the night, personal hygiene, medication, food shopping and cooking, going out to see friends and family, entertainment and leisure. There needs to be more individual budgets and the development of a job market for personal care assistants.</li> <li>8) Yes because communication aids are very expensive and difficult to obtain. It should be possible for the disabled person to obtain the funds to go private to get the assessment and buy the equipment themselves, not wait years for the NHS to fail to do it.</li> <li>9) shouldn't be any more difficult than obtaining car insurance. have a look and see what they do.</li> <li>10) video evidence taken by the assessing health professional</li> <li>11) when the person has a communication disability or has autism or a learning disability and is likely to agree with whatever an authority figure says.</li> <li>12) 3 years just like motability</li> </ol>

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	<p>13) I dont know. some people dont respond unless you attach a prize or payment            ?) yes            ?) Yes. currently obtaining communication aids depends on a specialist assessment which is hard to obtain and subject to contest by non specialists who are not involved in the assessment. There needs to be a national system so that getting a communication aid is as simple as getting a hearing aid or glasses and it can be paid for from DLA</p>
ONLINE457	<p>2) leave DLA as it is and use the money that it will cost to impliment the changes to catch the fraudulent claimster that give DLA a bad name, instead 2</p>
ONLINE458	<p>2) The present system allows the receiptian an award for life, whilst I accept there are those who may fortunately recover from their disability, there are those who are unlikely to ever recover from their illness or disability. It is for these people that some form of additional time limit is given, so that they do not have to be continually reassessed on a regular basis. It would be unfair and somewhat degrading to have to go through a constant reappraisal of their condition. I feel sure it could even have an effect on health and wellbeing. A check with their GP or medical advisor would answer many of the questions, failing that a requirement of short questionnaire would possibly surface.</p> <p>3) It is dependent on the individuals ability as to what additional cost maybe incurred, people with mobility problems may require additional costs with transportation, movement within their home or assistance with everyday requirements. Elderly people may require expenses over and above those who are younger, as people with debilitating illnesses when older become much more frail. It is difficult to gauge the extra costs without carrying out individual assessments, but on the other hand one cannot group all disabled people in one category.</p> <p>4) I do not see why there cannot be two different rates of the component, a disability can affect people in a number of different ways. One person who has difficulty in their mobility may be able look after themselves, ie washing and dressing and feeding but have have difficulty in walking to the shops or other venues. Another maybe completely disabled and require continual help to dress wash and feed, apart from being unable to walk or travel to a destination</p> <p>5) Tis requirement does need reviewing, but one needs to be aware that a person who is suffering from a lifetime diability does not want to be continually re-assessed even for a period of a year, when it has already been established that there condition is for life. No one wants to be reminded of the condition that they are suffering, again a check with their Gp or medical advisor would answer the question without the need to put extra stress and uncertainty on the unfortunate individual. There are a number of conditions that do not have a medical response or cure. This could be a cause for doing more arm than good.</p> <p>6) The first priority would be to give the individual support to help them to become more independent, although this may not always be achievable, it would be an aim that in the long term would give the claimant a sennse of being independant and less reliant on others.</p> <p>7) The assessment must be geared to the individual, not be intrusive, forcing an aid of any description would and could have the reverse effect. Again the medical profession with its vast array of knowledge should play a part. If the condition of a claimant changes, as some disabilities are progressive then perhaps they should be given the oppurtunity to be re-assessed, either by contacting their Gp or Medical advisor. Similary the advent of some new drug or aid could be described by the Gp which after trial and found suitable, could result in a review of that persons assessment.</p> <p>8) It is difficult to place an individuals need in this question. Purchase of or supplying aids do not always meet the right response. I think that aids and adaptions could be part of the assessment, but it would be the individuals right ot refuse, if taken a short time scale should be given for the user to feel that this is the right course to take. If a person already has an aid or some adaption to assist their everyday needs, it should be taken into consideration as repairs or updating are a factor in keeping them operational.</p> <p>9) Keep it in plain english or other dialect. Direct that the claimant need not be the person who completes the form, if help is required then it should be available in one form or another. Those who are unable to respond in this way should be advised that a welfare worker could make a home visit, people who are in this catergory do not like speaking about their condition, and assistance should be avaiable from their Gp or Medical advisor/social worker. These people have access to them on a personal basis, and keep a record of their progress</p>

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	<p>10) The medical profession have the medical records of the claimant, the carer or spouse also have a part to assist in the assessment as they are often as not the person who has daily contact with them.</p> <p>12) Again this information must be obtained from the Gp or Medical advisor. There are so many different variations of disabilities that one cannot form a judgement. It would be unfair to categorise a person who says suffers from Multiple Sclerosis as all having the same problems. The disease can be extremely ferocious or linger for years but at the same time be progressive, but with no known cure. This would be an example of perhaps a letter to the claimant after a period of say two to three years, to update the system or relying on that person to inform the DWP of changes in their circumstances. A similar view could be taken with a claimant who has suffered a stroke; Both these examples are for life.</p>
ONLINE459	<p>1) Physical impairments such as :-  Pain  Lack of balance and control  With a spinal injury, spasticity and spasms  Lack of toiletry control  Inability to walk more than a very short distance and stand or sit for any length of time.  Public transport such as buses and aircraft cannot be used and private road vehicles have to be used.  Windy or slippery conditions can make going outside the home very dangerous.  The use of aids such as walking sticks or a wheelchair prevent the use of the hands in the normal way. Picking up items in a shop may be impossible if they are stored too low or too high.</p> <p>If a carer normally does the cooking and it is only practical to have one kitchen in the home the drastic and expensive alterations required to make it practical for a wheelchair user to do some cooking are ruled out as the able bodied carer would then be hampered using the same kitchen.</p> <p>The need to have a carer to assist with opening some doors and gates and ensure safety in some environments. Even after the Equality Act access to some public spaces parks and common land is barred to wheelchairs and disability scooters. Requiring an expensive carer to unlock RADA locked gates etc. Some shops, banks, and public buildings prevent independent use and in some cases any use, making expensive alternatives a requirement.</p> <p>The difficulty of transporting wheelchairs and disability scooters can require large and expensive vehicles which together with higher fuel bills put stress on personal budgets and hence the ability to mix in society. In this regard the Motability Scheme has changed the lives of many disabled people and freed them from being restricted to the four walls of their home. Any change to the DLA payments that feed into the Motability Scheme would change the lives of disabled people immeasurably for the worse.</p> <p>Inability to do normal DIY and house maintenance together with the need for expensive disability equipment which itself needs to be replaced and maintained add to the expense and restrictions on normal life. As does the inability to do household cleaning and the washing and ironing of cloths. Even given a fully adapted garden with special tools and raised flower beds this still result in many gardening tasks impossible or too dangerous to be undertaken by the disabled gardener.</p> <p>5) I have a letter from the Benefits Agency that states that after adjudication, "what you are entitled to....From 08/09/1997 for life....You can get the lower rate for help with personal care....You can get the higher rate for help with getting around."</p> <p>The Government Agency that made this promise would have been aware that there was, and still is, no cure for spinal injury, only rehabilitation. I accept that in the extremely unlikely event of the discovery of a cure in the future, which would be world news, this decision could be reviewed.</p> <p>In the case of spinal injury it seems a pointless and expensive exercise, contributing only stress and concern to disabled people with spinal injury, to review this decision, when there</p>

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	<p>is no realistic possibility of a positive change in the situation.</p> <p>8) A person with a spinal injury who cannot stand without the aid of two sticks or crutches does not become able bodied by the provision of sticks or crutches. Equally the same person has the right to try and survive as much as possibly in society on their feet, and not simplistically be provided with a wheelchair with the erroneous idea this should cut their benefits. Some disabled people cannot face the trials and tribulations of trying to live in an able bodied world and simply retire to their bed or the confines of their home. This can be seen as part of, or an extension of their disability. Other disabled people put themselves through hell every day in the fight to get to work or join in every day society. It is a travesty to suggest that if a disabled person uses adaptations they should be considered less disabled and worthy of less benefit. Do we want a system that gives a perverse incentive to disabled people to use fewer adaptations and hence perform less well to insure maximum benefit?</p>
<p>ONLINE460</p>	<p>1) The attitudes of premises owners/controllers particularly Local Authorities, PCTs and NHS trusts who claim compliance but actually do not comply.</p> <p>Equipment supplied that is not suitable to an active life. For example the Wheelchair service provide wheelchairs only suitable for good metalled surfaces. If one wishes to go onto say woodland paths the supplied vehicle is unsuitable. Powered wheelchair users are similarly disadvantaged. An all terrain manual vehicle costs around £3,000 while a powered vehicle £8,500+</p> <p>Costs of travel are higher</p> <p>2) The way it runs currently is primarily marred by persistent supercissions even for minor circumstance changes even for the worse when the claimant is already on Highest rate. But the assessment is objective unlike the proposed system which is purely subjective with a smokescreen of claimed objectivity</p> <p>The application form is too long and has to be fully repeated at each supercission otherwise previously supplied and assessed information is ignored in the new decision.</p> <p>3) Fuel for vehicles as often a larger vehicle is required to carry all equipment</p> <p>Heating costs are higher for home</p> <p>Additional equipment is always expensive and retailers can often be reluctant to assist in VAT exemption when it is applicable</p> <p>Care help for toileting and bathing is expensive. Need full time when cannot use toilet alone</p> <p>These are a few examples</p> <p>4) It will not make it easier and has the appearance of cost cutting. 3 rates means a finer judgement can be made.</p> <p>5) Health conditions and impairments can be objectively measured unlike measures based on such as activity and thus must be used as a prime indicator of need. The proposed system will only be subjective based on the OPINION of an assessor. Not all assessors will be competent in all conditions and thus arrive at false opinions.</p> <p>6) Stop trying to assess full and active life measures as these are subjective and their use will only place pressure on the disabled at a time of stress. False claims are a small percentage according to DWP figures and the frauds should not be used to disadvantage the genuine.</p> <p>Any system of measurement MUST be publicly available with ALL measurement parameters</p> <p>7) You have identified why the new system should not be used - the variability day to day makes such an assessment impossible to do objectively. Look at condition as it can be objectively measured and abandon the idea that such variance can be measured - it cannot with any degree of reliability.</p> <p>8) NO - this leaves the path open to subjective judgements and defeats the governments aims. It is companies such as ATOS who are trying to create work for themselves that are misleading the government.</p> <p>It will also lead to those who do not actively try to do things being treated more favourably than those who attempt to overcome their disability.</p> <p>9) More reliance should be placed on appropriate competent medical practitioners familiar with the condition involved. Shorten the form and make use of tick boxes BUT descriptions of the consequences of the disability will always be required. Experienced help is required often but rarely available in short time notice periods.</p>

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	<p>10) There should be full use of reports from competent medical practitioners who are familiar with the claimants illnesses. These should be supported by the claimants own OT from the PCT/Local Authority. Reliance on external organisations who do not know the claimant will only lead to false decisions</p> <p>11) All interviews MUST be recorded and assessments made by people familiar with the claimant in their own home. All reports and questions/answers must be countersigned for veracity</p> <p>12) Too many superfluous reviews are already undertaken by DLA when minor changes for the worse are reported, as stated above. Random selected reviews would probably elicit fraud more easily or encourage change reporting. All reviews must be completed within 14 days to prevent unfair pressures on claimant.</p> <p>Fraud is an issue but it appears that good reliable identity confirmation is key to preventing fraud and this appears not to be done in all reported fraud cases</p> <p>13) See response to Q12 - The system encourages non reporting and thus permits fraudulent continuance of a claim that may once have been valid. A review of blue badge issuing may also provide a trigger for notification</p> <p>?) Devastating and costs for providers will increase dramatically</p> <p>?) No comments specifically</p> <p>?) No view</p> <p>?) No views</p> <p>?) No views on this but citizens advice service is overloaded thus another avenue is required. Funding and training will be an issue</p> <p>?) The disabled have to save for many one off situations. It is not easy to decide how one could make allowance for this in a regular payment. One could increase the amount but this would need to be reviewed after every time after a purchase. The availability of grants may be more suitable</p> <p>?) The proposals as they stand do impact adversely on many disabled persons and will increase stress among this population. There is no guarantee that assessors will be openly transparent and competent</p> <p>?) The use of DLA for passporting is vital but there are duplicate needs appearing in Local Authority as auditors ask for evidence on each and every spend</p> <p>?) These proposals will lead to confusion and there is a clear feeling that they are concerned with cost cutting rather than assisting the disabled.</p> <p>IDentity checking and random checks are critical for fraud prevention and may well produce greater savings than the intended potential benefit cuts</p>
ONLINE461	<p>1) Firstly, one of the key barriers that disabled people face is 'Access'. Getting to work, accessing the workplace, going out and buying food, socialising, using public transport attending interviews . . . every aspect of living that you can think of, can become a significant problem when as a disabled person you attempt to step outside the front door into a 'hostile' environment that does not allow sufficient right of passage for a disabled person.</p> <p>Secondly, the other major barrier for disabled people in today's society is an indeed always was, 'Attitude'. I noted that the report on your proposed reforms made a lot of grand assertions and sweeping generalisations about how society is so much more tolerant now, I'm sorry but that simply isn't the case and legislation like the DDA has no teeth!</p> <p>2) In my opinion, I would suggest that the system is far fairer now than your report would suggest - which is full of convoluted contradictions and again spurious and arrogant assertions. At the moment, while the mobility component allows in the individual to decide whether to use money to get a car or use it for the aids you speak of, such as wheelchairs or bath boards, the individual also has care component to help with additional costs of everyday living. This system works very well and covers the two main areas of concern you speak of. Not every one with a physical impairment is in direct contact with the healthcare professionals you seem to think are so necessary and yet the cost of living with a physical impairment is just as significant. The system as it is credits me with enough intelligence to figure all this out for myself. And no there have been no automatic entitlements, I would like to meet a disabled person who has not underwent at least 2 reassessments - in the space of 10 years. And if, they have been given an indefinite award, I daresay it's because there are some conditions simply don't change things will never change The Conservative Government needs to deal with the fact that there will always be a sector of society that needs permanent support, it's galling to Tories I know - but I suggest you save your</p>

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	<p>investigations for people with a real history of benefit fraud, either that, or stop handing it out to people with depression or athlete's foot. Just an idea.</p> <p>2) Personally I think the current system works very well. It is very much centred around the choices of the individual which is as it should be. The Mobility Component allows the individual to focus on the specifics of getting around, whilst the Care component accounts for the additional costs that disabled people face in everyday life. Not every disabled person has direct contact with healthcare professionals but this doesn't not mean that their impairment has less impact on their life.</p> <p>I would also suggest that DLA should not me used as means to determine whether a person is fit to work, however directly or indirectly, the cost of living is something that can be defined in monetary terms, whether someone can find suitable employment or not can be considered and determined in so many other ways. Currently DLA works as a way of defining who may need additional assistance in many different facets of society, that recognition is important.</p> <p>3) Mobility Care The existing system works,be decerning in the first place and you won't make disabled people pay for other people's mistakes. Do not put people's independence at risk!</p> <p>3) Mobility Care The system works this way! It is clear and simple using these two existing definitions. Do not risk the independence of so many disabled people, be making many disabled people poorer than they already are.</p> <p>4) Perhaps you could set a baseline amount which everyone entitled to DLA will receive and then add top up amounts according to specific requirements of individuals. The difficulty that two rates might cause is that individuals may not get the money they ought to be entitled to, because others outside the situation are making the decisions.</p> <p>5) I do not see a problem with automatic entitlements some disabilities are very clear and obvious. This is not like applying to your doctor for a sick note. There are disabilities that are life-long conditions and won't ever change, even with day to day fluctuations. What should be considered is the type of claimant that is recommended for DLA in the first place.</p> <p>5) I think there is no harm in automatic entitlements, it is a fact that there are conditions that cannot be cured, it is not like being awarded a sick not from the doctor. One may acquire a disability and again it should be pretty obvious, you do not get better from MS or if you break your back and become a wheelchair user, it's obvious there is no going back from that.</p> <p>6) By asking the individual, what activities are essential for everyday life varies from person to person, and may not always be best determined by external forces. You can prioitise support according to what is being asked for, and deemed justifiable and fair.</p> <p>6) That varies from person to person and such things should not be determined by anyone but the individual. Considering this form says it is not based on the medical model, sounds very medicalised to me. Which if funny considering the report stated it wasn't going to take the actual physical impairment into account in the same way as it used to - can't have it all ways. Either I need a wheelchair or I don't, how I move about in it can not be defined with a cash sum!</p> <p>7) If a claimant states that their condition is variable, fluctuating or degenerative then review the situation after an amount of time.</p> <p>7) The sensible thing would be to review the situation after a given amount of time if client indicates they have a variable and fluctuating condition.</p> <p>8) Every aid and adaptation should be included and people will always always need to replace aids and make new adaptations in future. Whether I use a wheelchair or not is the salient point, not how - that should not be defined in monetary terms.</p> <p>9) Make the most of sites like Facebook and YouTube-the internet is a powerful resource. Process applications online or over phone.</p> <p>10) My doctor AND ONLY MY DOCTOR! Not a thousand different well-meaning individuals who don't know me, with a thousand different interpretations of the matter. What matters is the FACT OF HAVING THE CONDITION. A doctor deals in ABSOLUTES AND CAN STATE MEDICAL FACT.</p> <p>11) SEE previous response. Keep it simple, the fact of the condition is the important issue. Multiple different visits, different professionals different letters are not only intrusive but lead to many different opinions being put forward, different versions of the truth, everytime</p>

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	<p>a review is carried out. It is better to have one person to vouch for you.</p> <p>12) It will depend on the claimant and their disability. The need for review could also be determined by a visit with your GP perhaps or an individual claim case-worker. Keep it simple and infrequent as possible.</p> <p>13) Ask people to fill out a questionnaire every so often or something.</p> <p>?) Currently, you would leave the individuals not having their disabled status recognised and this impacts upon support that can be made available to them in many establishments. Also things like the Motability Scheme is crucial to so many people. You would literally ruin lives if those passports were taken away.</p> <p>?) Doctor's report Other Benefits, Any history of assessments previously carried out.</p> <p>?) I feel deeply unsettled by the proposals I have read. I fear the approach that has been adopted here is medicalised despite good intentions and ultimately control will be taken away from individuals with the very real consequence of disabled people being forced to give up their independence. I believe the tone that has been adopted in the report is somewhat complacent and arrogant, the originators of these grand schemes seem to think society is all fixed and everything is just so, I am sorry but they have no idea. Making such massive changes based on such ignorance, sometimes insulting assertions and often spurious arguments, is unspeakably foolish and dangerous. I can only plead with you take care before fixing what ain't broken people's lives depend on it.</p> <p>?) Should state it's a non-means tested benefit that one is entitled too, gives other entitlements such as motability car blue badge etc. This benefit in particular can revolutionise lives, it really is one of those things that makes such a difference to people.</p> <p>?) There is a wonderful opportunity here to suggest that a special entitlement specifically for students with any form of learning impairment. So often disabled students fall by the wayside at school or college, because they need a lot of extra support and unless they have recognition they do not get the proper help, often the teir system of DLA has meant that parents of kids with significant hidden impairments like dyslexia and dispraxia have been powerless to assist their kids while they struggle to learn.</p> <p>?) This would be a brilliant feature if one-off grants/awards could be made available that do not effect your overall claim. Wheelchair repairs for example can be massive and terrifying if you are unemployed.</p> <p>?) Very important, sometimes a blessing and a curse if the passporting is to continue be very careful about which claimants you turn down cash too - you could be denying them critical support in other ways that have nothing to do with cash.</p> <p>?) Whether one is entitled or not to a disability benefit surely does not impact upon issues of Race Gender and Sexuality? If you are asking about whether these issues have socio-political implications for a disabled person then yes absolutely the world is full of attudinal prejudice which at times is not helped by these other factors, but that is not the issue here.</p> <p>?) Yes. For some assistance could be given to help fill out form if necessary, this resource could be available on request.</p>
ONLINE462	<p>1) If the disablement is one of which is affected by pain and/ or fatigue the person will never be able to predict when it is at it most debilitating state therefor planning an independent life is out of the question. This concept for others to understand is just not comprehensible and highly distressing for a disabled person. The extra energy consumed just getting through a day is a lot higher than able bodied person getting by. I have ms but am referring to stroke and card vascular patients too. Personally I m age 46 and never even imagined how isolating my disability would become the majority of people close to don t know either. Because I present well people think I m awkward for refusing to go to functions etc ... SufferIng vertigo too which stops me from being independent. My mobility is obvious problem everything else is invisible.</p> <p>6) Benefits made easy for needy - at moment you need a degree and a spirit level to sort them. The phone call and forms etc are beyond what a disabled and sick person is capable off. This makes situation worse.</p> <p>7) This is difficult because person with fluctuating needs will not be able to function so they will not want to fill a form in at worst time or even say how they are because they are just too sick to be bothered with anything. when a person is at their best they will attempt Form etc but will always look on bright side as one really does want to feel better.</p> <p>11) Face to face is good but to get the full picture it would be best for dla to talk to the care agency workers who are the most valuable people in the service users life. They are the</p>

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	<p>forefront of information and like the disabled not as valued as they should be. The nvq level 3 are the people dla need to contact.</p>
ONLINE463	<ol style="list-style-type: none"> <li>1) There are many barriers - access,employment,society's attitude to mental health to name a few.</li> <li>2) Supervision should remain as a criteria especially for mental health as someone with mental health issues is very vunerable and at risk of suicide and self harm</li> <li>3) transport costs,social activities and domestic help</li> <li>4) The lower rate should be kept as many disabled people qualify for help cooking a meal</li> <li>5) Automatic entitlement should remain - these conditions mentioned in annex 1 are not going to change and as long as thjere is medical evidence from a doctor involved with the person's care they should receive the benefit.</li> <li>10) This should be the doctor or consultant who the person sees the most not neccessarily the GP who may only deal with the prescription.</li> <li>11) This is very inappropriate for those with a severe mental health condition.A meeting with a strange doctor could be so stressful it triggers a relapse.Also there is difficulty for such people when engaging with doctors even those that they know so it would be impossible to do an assessment of someone who could not engage.</li> <li>12) Reviews should be between 3 and 5 years depending on prognosis</li> </ol>
ONLINE464	<ol style="list-style-type: none"> <li>1) The mobility element of DLA is crucial to people with disabilities. Particularly those with walking difficulties. Public transport is invariably inconvenient in so much as the bus stops are too far away from the persons home and the destination. It is also impossible to carry shopping while relying on buses. It would be very restrictive to work and social activities.</li> <li>2) The mobility element of DLA is crucial and should not be altered in any way</li> <li>3) The cost of getting about. Without the mobility element.People with walking disabilities will be faced with paying for taxis if they are unable to use a bus service. Which many Councils are withdrawing free services from !!</li> <li>4) Making the benefit more complex by adding more levels will cause confusion amongst claimants leading to inaccurate claims It will also place greater work loads on the dept. Particularly dealing with inaccuracies or fraud. Benefits should be simple and easy to administer</li> <li>5) Yes there are health conditions that are obvious and should be automatically be awarded benefits as some are currently.</li> <li>6) The need for professional medical evidence to support claims. Most health conditions are provable with the correct medical checks. Care in the home for severely disabled people is crucial as is the ability to move about both indoors and outside. The way to prioritise is to employ more investigators to sift out the false claims. Thereby releasing funds for those who are entitled to them</li> <li>7) Depending on the health conditions prevailing at the point of claim should indicate if further medical evidence is required if further claims were made after the initial benefit period. This would not need to be actioned if the heath condition was not expected to improve over time</li> <li>8) the use of aids should not adversely affect a disabled persons right to claim. For example a person without legs needs to use a wheelchair. A person with severe walking difficulties needs to use crutches or sticks. Is it right to exclude either of those individuals because they have some mobility with the use of aids. Similarly people who can care for themselves to a degree with the use of aids but still need care with other activities should not be discounted as not being in need of financial support.</li> <li>9) All claim forms can be made simpler. However they still need to be comprehensive in order to ensure the right people get the help they need. I think more emphasis should be place on claimants drawing on the services of experienced and qualified organisations to assist with the completion of forms. Funding should be made available to such organisations to carry out this work. It would have several benefits to both claimant and the Dept. It would ensure that forms were completed correctly and accurately, and assist with weeding out false claims if used in conjunction with firm medical evidence</li> <li>10) In most cases doctors and other professionals are best placed to give information on a persons disability and how it affects their lives.</li> <li>11) I feel face to face discussions with healthcare professionals are essential to the claims process. Anyone with disabilities that justify DLA should already be under the care of a doctor or other professional health worker. I see no reasons why this should not be a requirement in the claims procedure.</li> </ol>

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	?) I have given up on this document as it keeps failing and dumping my responses. I feel its been a total waste of my time and have the feeling that it is intentional to prevent a proper consultation being held
ONLINE465	1) They need to be able to get to places.Disabled people find transport one of the most challenging obstacles to overcome when trying to access the wider world. I appreciate we have to make disabled cutbacks, but if your cutbacks prevent my disabled daughter from having any chance of a normal life, i will find a solicitor and happily bankrupt myself in the process to hold you, 'the government' accountable. You can't pretend all carehomes are going to be able to offer clients transport to meet their needs? What if the clients all want to go to five different places? Making them all go to one, means the ones that wanted to go to the other activities are NO LONGER HAVING THEIR NEEDS MET. Basic human rights discrimination.
ONLINE466	<p>1) The whole problem with being disabled and leading independent lives come down to support and mobility. Accessibility is no longer that much of a problem as most places are catering for disabled customers. More of an issue are things like bus transport where there are selfish individuals who park baby buggies in wheelchair spaces. Forcing disabled people to rely on public transport is a cruel punishment by denying them mobility payments kills having a social life. Most social events are in the evening and public transport is not an option. The cost of a taxi is prohibitive to anyone on a low income so as a result, you don't go out. Relying on friends is not fair on them or the disabled individual - the whole principle of DLA is to live and independent life. Since when is reliance on others for access to social contact being able to lead an independent life?</p> <p>As for working, having an understanding employer is crucial. The fact that a disabled person will have to work at a lesser capacity than an able bodied person will place strains on colleagues that they may not be willing to accept. There are very few employers who will gladly accept disabled employees and provide the correct support to enable that person to work effectively. Most simply do not want the extra costs involved.</p> <p>2) Leave the benefit alone. It is fit for purpose. The problems lie with the form and its sheer incomprehensibility and over complexity. Unless you fit into one of the rigid boxes, you won't get the benefit. The form encourages individuals to lie by forcing them to fit into the boxes.</p> <p>There are also problems with the interpretation of the information given and the insistence on specialists reports. I've not been under any specialists and consequently fell into the net of having a medical by ATOS that can only be described as woefully inadequate. Sacking ATOS would save a fortune an vastly improve the service with DLA</p> <p>3) Heating in winter, transportation costs, personal care costs, cleaning costs, water rates, laundry</p> <p>4) It will make no difference. The reformed benefit will just loose one care level and will make no differencnt to the decision makers</p> <p>5) Yes - the rules are being applied unevenly irrespective of the medical condition. The Decision Makers Guide that the DLA use gives guidelines for each condition and even these are no being applied either fairly or evenly. There is no latitude for variability of a medical condition during the day.</p> <p>Even those terminally ill are being refused DLA after their claim is assessed (which takes 13 weeks). This is despite the ruling that terminal illness is exempt from normal criteria</p> <p>6) Allow input from carers and friends in assessing a persons ability live their life. Know the condition they are suffering from before applying a judgement to that person ability to live. Accept that people have complex illnesses and are not all liars and cheats would be a huge help</p> <p>Get rid of ATOS and get rid of the bonus they get paid for rejecting a claim</p> <p>7) Accept the diagnosis and the GP's view. I have a variable and fluctuating condition and it varies from hour to hour, let alone day to day. This is not accepted under the current criteria and I am deemed fit and able to care for myself when I am not. Knowledge of the patients diagnosed conditions would be a huge help instead of blind reliance on the information on the form</p> <p>Bear in mind that the GP does not always see the patient in the home environment and may not be qualified to comment on a patients ability to wash and dress themselves. Allow comment by friends and accept photographic evidence of living conditions</p> <p>8) Yes and make sure sure they are used. If there are no adaptations, ask why not and</p>

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	<p>would the person benefit from them. Social Service are grossly overloaded and I am still waiting for reassessment for an additional shower rail 6 months after the request was made.</p> <p>9) Make the form less complex. Make it less repetitious Explain clearly the information the assessor is going to need to examine the claim. Train staff to specialise in certain illnesses to allow for a fairer claim process. Allow call centre staff to make notes on the claim system so that assessors can see patterns of contact Train more staff to be able to assess claims fairly then there would not be the 13 week delay for initial examination, then another 13 weeks for a re-examination then the massive overburden on the tribunals service caused by the automatic refusal of the majority of claims and renewals. They would also have lower caseloads and DWP would loose less time to employee stress-related sickness</p> <p>10) GP assessment along with patient estimate of abilities. If a specialist report is available then this should be used but remember that a specialist and GP are limited to the information given by the patient and they may not have a full assessment of the patients home life and limitations. ATOS should not even be considered fit to give an opinion on a ptients home life based on a short interview given in an 'assessment' centre</p> <p>11) There are enormous problems attached to this as it is likely to be a process fraught with errors. Our local 'centre' has no on-site parking and being able to walk from the car park across the road for the assessment, even with assistance deems you as not requiring mobility. They monitor this from the office window. The ATOS doctors tend to arrive on your doorstep with a whole hidden agenda and no prior knowledge of your medical history. How can they be expected to carry out a fair assessment with no information other than that given by a sick patient? The examination given is cursory to say the least with the final report bearing little or no relevance to the actual situation. We are also hearing that 'healthcare professional' now need not mean a trained doctor so how can a few weeks of training replace years of experience??</p> <p>12) Medical evidence must form the basis of the review with greater weight being given to the primary care doctor as they see the patient far more often than any specialist. The reviews need to be set on the basis of the condition and the likelihood of any improvement. ie a severe mental illness like bi-polar should be on a 5 year paper review and a deteriorating illness like MS on a 3 year review. Things like back pain should be on a shorter review as it is an improving condition unless it is part of a longstanding condition like arthritis or spondylitis.</p> <p>13) Outgoing telephone call at fixed intervals to the claimant. That way, any suspicions can be reported back much earlier of improving conditions. I'm suggesting being pro-active instead of reactive</p> <p>?) Make it clear what qualifies as evidence for the process so that even if the information is not ready when the claim is submitted, then at least it is in process and can be submitted once it is available. A list of advocacy services to help people complete the forms would be very helpful too as this form is extremely complicated and hard to complete alone. It would be impossible for some complete it</p> <p>?) Most fund their adaptations via social services or savings if they have any. There must be an option to make a one-off payment to fund such adaptations ie in the case of an accident victim where there is an immediate need so they can continue to live in their own home.</p> <p>?) The whole reason for the system being in such a mess now is that many people did not know that they were eligible for DLA and are now claiming it, not the feckless claiming for minor ailments. An independent service to offer advice and support would be the best line to take but this must not be part of ATOS or the DWP but a wholly separately funded service with trained staff. The emphasis would be on the staff to advice correctly and offer advice on completing the forms. Things to avoid would be keeping this in-house with an existing service provider as they would not be able to offer impartial advice.</p>
ONLINE467	<p>?) Is there any reason why a form can't be sent out to everyone annually specifically asking about changes with some summary of the previous assessment?</p>

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	<p>I have suggested it is unnecessary to people with conditions that won't change</p> <p>I wouldn't have thought the costs of administering over-regular checks on everyone directly would be worth it.</p> <p>The original assessment should identify those people whom you might call irregularly for review and those whom you would send a form - with the appropriate warnings.</p> <p>Random spot checks could be done, but with care not to end up with over-bureaucratic over-assessment.</p> <p>If someone's situation changes eg employment you might want to review - but I'd suggest after (say) 6months and taking account of how the PIP help might be enabling work</p> <p>1) The inability to manage basic needs without support of some kind. Local authorities (LA's) only meet some areas of need such as personal care needs and are increasingly reducing the help to wider needs and increasing charges including taking DLA income to meet needs. LA's often don't recognise disability needs outside their narrow range in carrying out financial assessments - and for example Lancashire CC in their current plans are talking about making standard allowance disregard from disability income to meet needs - which appears to be contrary to tailoring to individual needs. Barriers are thus also about the need to ensure that the support given by one authority is not undermined by another's actions. People want as much control as they can or if they lack the capacity/ability the support to sort out the right kind of support to optimise their independence. People not understanding the importance of help to develop social relationships and activities as vital needs is a major barrier. Insufficient funds to enable people to meet their individual needs.</p> <p>The ways support is given can often detract from developing more independence and the cuts being imposed in local authorities are pushing the opportunities for more individualised support in that support has to be increasingly shared - this leads to more dependency models of care - as doing FOR someone is cheaper than helping someone to do for themselves.</p> <p>The intention to remove DLA mobility as well as care if someone has to go into a residential home will also take away vital, finance for people (particularly working age adults or young elderly with significant physical disabilities, mental health and learning disability) and is likely to create very dependent lifestyles and trap them for the most part in the home.</p> <p>A concern I'd also have is that given the local authorities have mainly removed moderate and low needs for support from their equation of eligibility for care, it would seem important that the government do consider a low level support as some research has shown in mental health for example small amounts of support can facilitate developing more independence and facilitate recovery or maintenance. A real concern is with changes of PCT commissioning to GP commissioning. the 28% cuts in local authority funding which is directly impacting on services to children and adults and a government review of the DLA funding - having taken away the ILF funding and also capping mortgage funding from DSS - all these seem to conspire against more independence.</p> <p>?) Aids/adaptations, housing advice, maybe signposting to any welfare rights, advocacy, voluntary sector CAB etc, volunteers support, employment and possibly to adult services for care assessment or to health services eg for mental health support. Sources of getting best out of related costs - eg broadband/computers, telephones, private aids...</p> <p>It would have to be helpful as part of the process of applying in order too to identify what help they are getting and what else might help</p> <p>2) I am concerned where there are long-term needs such as learning disability and physical needs as well as some long-term chronically disabled by long-term mental health problems, about the potential over-review. People are already assessed to the nth degree in health and adults social care, employment, education etc, and I would hope that some degree of universal entitlement such as the DLA could in some cases be reviewed by</p>

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	<p>ensuring there is someone to assist the person where they are unable to fill in a review form only,, and that on initial assessment this is determined. Equally if they are assessed as in need of substantial or critical social care then this must show the need for disability income I'd have thought.</p> <p>I'm also concerned about the need for people with less needs who won't now get help from the local authority but without some extra help may become more disabled - so the lower level DLA could make all the difference including due to passporting people into free bus passes etc, so I'd like to see some consideration of this in view of the total lack of support for this group.</p> <p>Equipment such as electric wheelchairs; postural care aids; mobility scooters etc - all make a huge difference</p> <p>3) Mobility costs to get about are more than just whether people can use public transport or not physically. Some people for example with mental health problems may have problems getting out which can be helped by a wide range of different supports - from using a taxi; someone to go with them; maybe a mobility scooter; a motivating activity... others with learning disability would not be able to use public transport without someone to go with them; might need to use taxis to be able to go somewhere independently of support; some people's behaviour means that they don't understand waiting for a bus, others in the queue; the need to get on a bus promptly etc - and some people's communication methods might be upsetting to other users eg screaming/ swearing.</p> <p>Vital to people's well-being is the support to participate in activities - this includes access to social interactions. This may need people support as well as passporting to leisure/college etc or finance to pay for some activities. Increasingly these areas are not being met by the local authority and the pressure on cuts is reducing individual access.</p> <p>What needs to be considered is also how the local authority assesses people's disability income towards assessed needs where they are eligible - needs need to be excluded from the assessments which DLA currently supports such as access to leisure and holidays.</p> <p>Help to access in different ways such as through using broadband - eg to do shopping; book things on line - even do courses. People often at income support levels can only do this if they have the extra disability income.</p> <p>With extra income, people can also access a wider range of aids themselves to help their independence. This is likely to take off other services the costs of always having to go through health professionals. Telephones are also another area of importance</p> <p>An area rarely taken account of is where people are unable to go out without the support of a carer. The costs of the carer's bus fares, meal out, show, entry fees etc are all currently met from the DLA income and represent a major area of cost for the disabled person. This also applies to going on holiday where the costs can be having to pay for a carer to be there all the time as well as all their costs - travel, accommodation, extra costs of meals away, entry fees etc..</p> <p>?) This suggests the assessment would need to be more sophisticated and end up with an agreed plan for the use of PIP and other areas. I don't think enforcement will help - the essence of getting a benefit is for the person to direct how best this would help. Advice can be given and direction to sources of support but I think beyond this is not acceptable. Advice and if available the offer of a volunteer to help them access/support them to make the first step... but definitely no more than that</p> <p>4) As I've indicated above, I think taking away the lower level could seriously affect some people with more moderate needs - currently ineligible for local authority support in most LA's.</p> <p>I am also struggling with how having two single rates is likely to be appropriate to a more personalised approach. My experience has been the high, medium and low levels work quite well to the kinds of different needs people have with different levels of disability. I'd have thought that people with medium and high levels of need are likely to be those at substantial or critical need under the FACS criteria - and this might be a better way to</p>

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	<p>allocate this. and that those with low levels of DLA are likely to be those who are going to end up with no other support so it could be critical along with the signposting</p> <p>?) Often they do use resources to purchase one-offs - some of which can be paid over time. so yes whatever best helps them</p> <p>5) As I've indicated above, there are some people, who already have had assessments of need by competent professionals - health or social care - and whose needs are assessed as severe or critical and ongoing/unlikely to change. I can see no point in yet another assessment. They should be eligible and the application form could identify such a person for you to contact to verify need.</p> <p>some such people will be people with serious physical and/or health disabilities; some people with long-term chronic mental health problems which seriously restrict their ability to lead their lives and people with severe and profound learning disabilities where their levels of capacity mean they will always need a high level of support and depend on others for any measure of independence/control.</p> <p>I feel it is those who don't now qualify for social care support - who have moderate and low support needs who will need the assessment and who may well need this kind of support if we are to avoid them developing increased needs. An assessment could help them identify how best to use an allowance and signpost them as well as keep them under review.</p> <p>I am however concerned about the need to ensure skilled assessment which understands how different disabilities manifest themselves. For example some people with a more moderate learning disability can "pass" as having more understanding than they do and are often anxious to appear OK - but are often some of the people most at risk of losing independence if not given some low-level support. This might help if given some direction as well about how it could be used best to help them manage.</p> <p>5) The impact on the family carers and how their support can be best helped too. There may be more likelihood of more frequent changes in some children as they grow up - more likely to have changing needs which may need more help as well as less</p> <p>?) I think passporting to such as free bus travel and other local leisure etc concessions such as free cinema for disabled people's carers have been vital to people making progress in developing a life.</p> <p>6) See above re targeting assessment and also putting expertise into assessing people who might appear to have lower level needs.</p> <p>Helping people with their day-to-day routines; eating, cleanliness, personal care/health needs and ensuring everyone has someone in contact to assist/ask - signposting to somewhere that can help. Essential too is enabling people to get about to essential places but also to access some activity and social interaction - some people without this become very vulnerable to being targeted in the community</p> <p>7) By ensuring the initial assessment (including from professionals who know them and have already made assessments) looks at this. This means making sure those assessing are competent in the area of disability being assessed - which could start by ensuring this is clear on the application form. This could also be by ensuring any assessment takes proper account of professionals who know them well as well as those who have made formal assessments. (This could include service provider agency qualified staff too)</p> <p>By doing this it should be possible to make an estimate about whether there needs to be any review at all (some people's disabilities are so severe and permanent that there will be no significant change); if this needs regular 12-monthly review or say 5 year review.</p> <p>If people's conditions are by nature fluctuating then an assessment needs to be made about the range of needs - it wouldn't seem sensible to keep reviewing every short-term change unless it is enduring. If people have to have had a condition for 6 months before they qualify then maybe a change needs to endure for 6 months before the benefit changes.</p> <p>7) It could mean it was too difficult for people to prove their disability without it being over-</p>

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	<p>intrusive. It might then mean additional work for GP's or other professionals having to write to support this. The PIP should be used as a passport. The only issue may be whether there are some people who if they no longer meet the new criteria will be severely affected. Suggest this should be part of the assessment of support need i.e. do they access this now and what would be the impact on their coping ability if this no longer applied</p> <p>8) I would have thought that consideration both of what people use and what might help might be helpful to inform the assessment but this also means being absolutely clear about what the limits of the provision is as well as the potential of other aids might be if the person could buy them. (Currently for example it would appear that certain aids are not provided by the health/social care but which could make a difference. Good information is needed on what people are eligible for and what they have to pay for - DLA/Attendance allowance are often used to buy things which help.</p> <p>Support like the Care line and broadband access to the internet... need paying for</p> <p>8) See suggestions above re health care and social care assessments. I assume on key physical/medical issues this might be provided by doctors as part of the evidence</p> <p>9) I think this mainly relates to ensuring all assessments are well-informed by the needs of different groups. A concern I have is the often over-emphasis on physical disability and the risk that people with mental ill health are not seen in terms of their disabilities or how disabling their condition is for them. Equally as mentioned above, people with a learning disability - as the range is very wide this needs extremely skilled assessment often to understand how disabled they actually are and the impact - suggest that they should be encouraged to bring with them someone who supports them or who knows them well to help - or be provided with an advocate to help.</p> <p>The other area often misunderstood is ACD - how crippling this can be and asperges which if not well supported can lead into mental ill health for example - or even behaviours which can exclude people</p> <p>accessing different cultural groups needs an understanding of what is acceptable and ensuring they are in charge of the process and can direct this as well as the assessor's knowledge</p> <p>10) As above - use of other professionals assessments; help from others who know the person such as relatives, friends, service providers....</p> <p>The history of the disability; other services needed, aids etc; information on the condition and likely effect - permanent or temporary</p> <p>10) I would like to emphasise the need to ensure the whole situation is looked at so that people are not ending up with no support, nor that benefits of PIP do not end up just paying charges for local services only but people have the opportunity to spend this in ways which really make a difference.</p> <p>If professionals already involved are used in the process there is more chance of getting this joined up. Be aware of the need for GP's to understand any changes too to inform their commissioning practices.</p> <p>I am also concerned about if there is no low payment any more and if the income support disability premium is taken away (as this often contributes to such as heating or the need to spend more money on food - convenience; special diets...) Need to look in the round</p> <p>Given the very big cuts in LA funding which is directly impacting on disabled people and reducing their support, if there are cuts to disabled people's personal income there needs to be some compensation - maybe give the LA's specifically for SP to support housing needs; voluntary sector in local preventive community services. The other impact will be on the LA charges as currently they are all increasing charges on income to reduce the impact on direct services - taking sources of income from disabled people will reduce LA funding and services unless this is thought through.</p> <p>11) As I've indicated above I don't consider that everyone will need this if they already have had a health or social care assessment which can be used.</p> <p>Otherwise a health professional is not always the best qualified to assess the disability and</p>

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	<p>how this impacts unless they have the right qualifications.</p> <p>Often doctors have been used who often for example are not able to assess learning disabilities. This would be likely to be most important where people don't have such evident disabilities but where the impact may be serious on their ability to lead their life and keep safe.</p> <p>If the right professional is used they should use other sources of evidence where possible and encourage the person to be accompanied. If they are trained to signpost appropriately this could be helpful.</p> <p>Seeing someone in their home is likely to give the best idea and could even test out some of the day-to-day problems or reveal more about the person's actual ability to cope.</p> <p>There can be cultural issues to consider that should be taken account of - eg where someone might not be able to have an interview unless accompanied/need same gender interviewer.</p> <p>By seeing someone at home this may also reveal unmet needs so that the person could be referred to housing, health or adult services for assistance</p> <p>12) See above - I would suggest if people have long-term severe enduring conditions they should have a long-term assessment; that otherwise review should not usually be more often than 12-monthly given they have to wait 6 months before they qualify, and for some 5-yrly might be more appropriate</p> <p>Ref changes in need - up or down this should be able to be requested at any time, and involved professionals could alert this. It could be linked to the local social care assessment so that this Q is also asked there and the assessor is asked to indicate if there are any changed needs?</p>
ONLINE468	<p>1) I have experience of helping disabled people find or retain employment. The barriers I see them facing is reassuring employers that they are viable employees. A lot of employers I have dealt with tend to see the disability as a barrier, especially when it comes to paying for adaptations, or their perceived idea that they will be limited in what they can do or have a high absence record.</p> <p>I have also seen disabled people leading very restricted lives as getting around using public transport can be a problem. Depending on their disability, some find it difficult to use the transport itself due to their inability to cope with crowds of people. Others find it difficult to use as they are unable to read timetables or cope with changes either to routes or timings.</p>
ONLINE469	<p>1) Any disabled person has the problem of participating fully in society because nothing is catered for them fully.</p> <p>Not all types of wheelchairs can go on buses or taxis. If they do and the vehicle is already holding a disabled person in a wheelchair/scooter, then this person has to wait until another vehicle is available. This means their appointment has been missed. They have missed out on a job, or even get classed as not reliable because they are late. Not all jobs are catered for a disabled person either. Some disabled people cannot sit too long, without getting stuck and in pain; they have to be at a certain height too. If they stand too long they can also get stuck or even fall if they try to do this too often.</p> <p>Not all doors are eligible for a disabled person to use, this means they cannot always get in shops, doctors, hospitals, pubs, or banks. If they can use the doors they will find steps so they cannot enter. They sometimes have to use the luggage or shop goods way in because the place is not eligible for them to use the same way as their friends. A lot of doctors, hospitals, toilets all have doors that are too heavy for them to open too. Sitting in a wheelchair does not enable them to push open doors.</p> <p>When shopping things can be too high, too low, or down an aisle that is too narrow. Lifts can be too small too.</p>

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	<p>Streets don't have enough dropped kerbs so the disabled cannot always cross a road safely, without hurting themselves.</p> <p>2) The mobility car should stay the same. This is what a lot of disabled people need to stop them becoming housebound. Without the car more ambulances will be used for hospital appointments. Some disabled people will not even get to their local doctors or dentist. This is part of a disabled person's life.</p> <p>3) A lot of disabled people have bathrooms and kitchens made to measure to enable them to be more independent. All of this costs. If they no longer had the money to pay for these things different benefits will start being applied for or the person will become isolated, ill and afraid because if possible everyone likes to be independent and they no longer will be able to be. Also disabled people use the money for travel costs if they cannot use or drive a car. They spend extra on wheelchairs or scooters to give them independence. All of these need maintaining, yearly and wheels, tyres, batteries some times need replacing. For the disabled person to sit and sleep correctly, special chairs and beds need to be bought. Comfort around the home is always needed, after being in a wheelchair solidly.</p>
ONLINE470	<p>?) It has been TOO useful! There is also contradictory legislation between the Blue Badge and Freedom Pass, such that currently those on DLA HRM get a Blue Badge automatically and ALSO a Freedom Pass. For most applicants for the Freedom Pass explaining how they are unable to walk and their mobility is severely impaired, they would not be able to use the public transport system! Also a lot of people take the other entitlements, even though they may never intend using them, just because they can. In addition, most people who are refused the other entitlements, such as the Blue Badge or Freedom Pass simply make a claim for DLA JUST so that if they are awarded HRM they can then claim them. And, on top of that, they also get the additional income. This drain on public funds HAS to stop.</p> <p>1) Mostly themselves. The benefits system encourages people to focus on and exaggerate their disability for the sole purpose of getting benefits and other concessions such as the Freedom Pass, Blue Badge taxicard etc. One should expect that someone diagnosed with arthritis SHOULD be able to get on with a normal life, instead the impetus is for that person to say how debilitated they are such that they need DLA, A Blue Badge etc..... as an example, all the forms that they complete focus on what they CAN'T do rather than what they CAN do. The genuinely disabled are being undermined by those who play the system and money could be better spent on helping the Blind (for example) than throwing money at someone because they have 'back pain' and therefore( as I see every day) "can't walk more than 50 metres, can't mobilise, in pain every minute" but I want a Freedom Pass to get out of the house", as if touching the Freedom Pass suddenly gives them the ability to walk. The truth of it is that TOO many people want to see themselves as disabled, only for the purpose of not working/ benefits. The genuinely disabled who have to pay for carers and have no independence are those who should be taken better care of, rather than the millions of people claiming DLA because of back pain or arthritis. I have dealt with hundreds of people in my daily work capacity who are on DLA Higher Rate mobility and there is absolutely nothing wrong with them.</p> <p>1) None, and nothing. Those who do deserve it will still be in receipt of a benefit and those who don't deserve it, and never did, will have it taken away from them.</p> <p>2) No. It is a flawed system, especially when you use the words "long term health condition" as it applies to most things (other than broken limbs) and is enabling too many people to be on a benefit because of arthritis or back pain. Even with osteoarthritis, most people of a certain age will get it as it is age related, so why give DLA to people for age related degeneration? With the terminally ill, make sure of regular reviews such that you are not giving out DLA with the expectation that someone has only got (for example) a year to live, yet you are still paying out DLA to them 7 years later! (As has happened). Whilst I understand the need to encourage people to work whilst in receipt of DLA it makes a mockery of it that someone on Higher Rate Mobility (HRM), but NOT in a wheelchair is able to travel into London every day with a free travel pass, yet if they were truly "unable to walk, or virtually unable to walk or the exertion required to walk would constitute a danger to their lives" they should not be able to get on a train and hold down a full time job! Also, people have to understand that DLA is not ADDITIONAL income, it is there to help them with the additional costs of their disability, so if someone receiving approx £200 per month on DLA HRM has to go to Barts hospital once a month, then they should fully expect to pay their fares out of their DLA and not have free travel JUST because they are on DLA HRM.</p> <p>2) Only those who truly deserved the other entitlements would have access to them and</p>

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	<p>vice versa. There are too many people out there on DLA HRM who ABSOLUTELY do not deserve it, and there are also now getting other entitlements that they ABSOLUTELY do not deserve.</p> <p>3) Care needs, cost of medicine, and travel for hospital visits. BUT, if you are taking the cost of travel into account, then they also shouldn't be able to get extra free travel, or they should have to trade of their DLA award for a travel pass (if proved that they need regular hospital visits) that would cost MORE than the Freedom Pass is subsidising.</p> <p>3) Have one assessment of the person as a whole, and cross reference with other benefits. If you are assessing their disability and it is clear they are still capable of work then other departments should be aware. For example if you cross reference with housing departments and social services, you will see that most people who are in need have had adaptations in their home, or have actual care packages in place, whereas those on HRM just to get other benefits are not accessing any other services. If you know that a person is living in a house with stairs, and travelling to London on the train to hold down a full time job then you know that when they say they are 'in constant pain, unable to climb stairs, unable to concentrate etc etc,' that it doesn't ring true!</p> <p>5) Absolutely NOT. No health conditions should mean automatic entitlement unless specific disabilities that will never change and do not vary across individual, eg someone who is Blind, or Learning Disabled, or Deaf, although even then their benefit should only relate to their additional needs. There should be absolutely NO automatic entitlement to other benefits such as the Blue Badge or Freedom Pass and the legislation for Blue Badges, Freedom Pass and taxicard NEEDS to change. ALL claims should be based on the individual. One person's arthritis (and tolerance levels) are not the same as another's. I have had arthritis since I was 13 years old....so what????!!!! Others would want to use that as an excuse for benefits.</p> <p>8) All aids and adaptations should be included. Just because someone walks with a stick doesn't mean they can't walk. I see hundreds of people walking into our offices with sticks who walk at the same pace as the average person, or who don't really even need the stick. I know of one person who was refused a Blue Badge for Back ache. He then started to walk around with a stick, applied for DLA, got given HRM, then got a Blue Badge and Freedom Pass and now.....is seen out and about without the stick! The assessment should take into account any aids that a person can easily obtain....or give them instead of the monetary benefit</p> <p>9) I don't think making it easier should be of importance, necessarily. It is about getting the RIGHT information in order to see the varying degrees of the disability easier. For all the millions currently on DLA, they obviously got over the "hardship" of the form filling! I don't think the GP should be referred to as most people who have such a debilitating disability to qualify for DLA would be under the care of a consultant. To be clearer about who it IS for, I think you need to be clearer about who it IS NOT for!</p> <p>12) Everyone should be regularly reviewed. The onus should be on the individual to confirm they still merit receipt of the award. Less indefinite awards should be issued, especially to mental health applicants, most of whom (that I deal with) are simply depressed or anxious! There should be different reviews depending upon the needs of the individual, but the best way is to get the award correct first time round so that there are less on the actual benefit and less needing to be reviewed. DLA is costing the tax payer too much money...</p> <p>13) You need to have penalties that are enforceable, and be able to take away people's right to future entitlement if they defraud the system.</p> <p>14) Only needs signposting to other areas. In some cases perhaps agree to fund the therapy rather than give the money.</p> <p>16) I think if you are able, for example, to supply support stockings and a walking stick to someone you otherwise would be giving £200 per month to then there could be worthwhile savings. For the average person to be given an extra £200 plus per month (HRM only, not even including care) when they do not have daily care needs or multiple hospital visits (and they already get free travel) is taking the mickey out of every taxpayer</p> <p>17) That their condition/s could change. Also that when they have a disability from a young age there is a certain amount of adaptation that takes place so simply being born with one leg shorter than the other (for example) should not necessarily entitle that person to a benefit other than maybe the additional cost of show supports/ special shoes</p>

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ONLINE471	<p>1) Isolation and loneliness, especially for the older person with disabilities.</p> <p>With this, a lack of confidence, and sense of self-worth.</p> <p>There can be extra problems when the illness/condition is 'invisible', i.e. one looks 'normal'.</p> <p>There is a subtle (and sometimes not subtle) pressure from those more 'normal', or with robust health, to be and act more like them - as if being cured or healed means to be like them, i.e. normal, whatever that is.</p> <p>It would help if people with disabilities could be appreciated more for who they are, and maybe the special gifts they may have.</p> <p>It would help if the public at large were much more informed about invisible conditions, especially heart conditions, and mental health issues.</p> <p>It would help if there were to be a much better diagnostic rate for rare diseases and conditions. At present this is very poor in this country, as stated by a Minister last year.</p> <p>Toleration and integration of those with physical, visible disabilities as demonstrated by wheelchair use etc, has improved within society, but there is still a long way to go with attitudes towards those who are outwardly fairly 'normal' but inwardly different because they are born that way.</p> <p>2) yes..when one has been awarded DLA or its equivalent 'indefinitely', indefinite should mean that. It is the most stressful anxiety to live under - that of fearing the award will be overturned or re-neged upon.</p> <p>Having said that, indefinite status should only be awarded when sure that this is appropriate, e.g. with genetically determined, incurable and/or degenerative conditions. For this, a good, thorough and accurate diagnosis is indispensable, so I would fervently hope that the importance of this will be emphasised in policy.</p> <p>3) Housing costs, especially appropriate housing. People with disabilities can have many special needs in housing -more than the obvious ones of access, ramps etc. These would include (from my own experience) :</p> <ul style="list-style-type: none"> <li>- quietness : this is so very important, especially for those mostly housebound, and who need to rest or sleep in the day.</li> <li>- the environment and safety of it. neighbours etc.etc. secure lease.</li> <li>-freedom from damp, and also cramped conditions.</li> </ul> <p>These all have a direct bearing on one's health and quality of life.</p> <p>The other great cost is transport, especially if one cannot use public transport, and one does not drive.</p> <p>Heating costs are formidable -especially since one has no control on all the price rises. Heating is crucial for my condition. However, I have been greatly assisted by Cold Weather Payments.</p> <p>I do wonder about heating allowances being given to all pensioners whatever their status. I know 2 people who are pensioners who are healthy and robust, out most of the day, and well-off. They have told me they simply don't need the allowance.</p> <p>Housebound people with frail health really do. I wonder if more could be done to encourage energy companies to offer special rates to single people who are housebound with extra heating needs? They should be easy to discern from usage.</p> <p>I have extra costs with clothing and shoes, for which I have special needs due to my Marfan Syndrome.</p> <p>Also utensils and aids and special tools etc etc.</p> <p>I also have extra costs with a special diet.</p> <p>A good computer (and also a mobile phone , used like a personal alarm) is an essential for me now.</p> <p>4) As a matter of fact, I believe it would be better to have at least 3 levels of each component of the benefit, or, preferably, even 4 levels of each , that is 4 of each, the Daily Living and Mobility.</p> <p>I do not find it difficult to understand at all. it makes sense.</p> <p>I feel it would be good to work on how one could more easily shift between the different levels, to accommodate the fluctuation of illnesses and needs.</p>

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	<p>I think it would be good if there were less monetary difference between the levels -hence 4 levels could achieve this neatly.</p> <p>5) Some conditions or impairments should definitely mean an automatic entitlement. Again this points to a need for good diagnoses, as early as possible.</p> <p>I would think that being born with a potentially serious condition that is incurable -even if manageable - should qualify.</p> <p>If there were 4 flexible levels of benefits, then in such cases, one could automatically qualify for the first 1 or 2 levels, and then demonstrate need/circumstance for the other levels. Apart from anything else, this should save bureaucracy.</p> <p>6) How do we prioritise support? Perhaps by doing what this consultation is the start of : listening, and truly hearing too.</p> <p>Those most in need may also be the ones who feel too diffident and timid to speak up for themselves. This was me 7 years ago, after I had spent 23 years with 'something wrong' and no diagnosis.</p> <p>I wonder if there could be a link on the DLA site to a counselling service, which could, at the very least, re-direct people to where help for them might be forthcoming?</p> <p>As regarding the most essential activities, I would say there are essentially 2 :</p> <p>1) moving around. Just doing whatever movements one is capable of, and however much feels is right for oneself. Not giving in to despair and inertia, and having a positive attitude to pain management will enable gentle movement and activity. One needs encouragement for this, not criticism.</p> <p>2) social interaction - again as much of, and of the type that suits each individual. Surely absolutely everyone in the world needs to feel valued and appreciated for something...</p> <p>While the new interactions possible on the internet are an important development, they can never be the same as being actually in the company of someone. One quietly longs for sympathy in the form of understanding, and empathy, but pity, and well-meaning but ill-advised 'advice' is of no help.</p> <p>For myself, creative interests and projects have been pivotal in helping me through the difficulties in my life. I wish creative and cultural skills could be encouraged for people with disabilities . Apart from the increase in self-esteem and happiness that can result, a person can also, maybe, slowly build up to something that can become some kind of self-employment for remuneration.</p> <p>At least it gives one hope.</p> <p>Many people with disability are unable to go out very much, use public transport, or sustain themselves through a whole working day, especially in a competitive environment that the workplace often is.</p> <p>For many it is unrealistic to suppose this may change.</p> <p>But developing skills that could be used at home, in their own time and at their own pace, could be a genuinely constructive and realistic way forward.</p> <p>7) I believe an assessment should ask questions that relate to a period of 3 months minimum in the winter, and the same in the summer.</p> <p>perhaps ask the client to describe both their worst day and their best day, in their own words.</p> <p>As a way of monitoring myself I will sometimes think of the week in a ratio, bad days : good days = 6 :1 (winter etc), or sometimes = 4:3.</p> <p>At the Rheumatic Hospital we were encouraged to write an hourly diary for 10 days, then learn to recognize a pattern, and pace accordingly. I have found this one of the most helpful things.</p> <p>perhaps diaries of various sorts could be encouraged, and used for reference from time to time.</p> <p>Various illnesses are well-known to be fluctuating (rheumatism), and why (damp and cold). This should therefore be taken as a given, and factored in.</p> <p>One of the reasons I believe it might be a good idea to have 4 levels of benefit is that clients themselves could opt in to a lesser level when (or if ) their condition consistently improved over, say, 3 months.</p> <p>They could also opt back to the former level, if a serious set-back occurred, which would probably be registered with their doctor, and so justifiable.</p> <p>In my case this might be a fall, or a flare-up of existing condition.</p> <p>I think it would be worth giving the client such a responsibility : some would be able to discharge it.</p> <p>The main thing is that when a flare-up occurs, one needs extra help or treatment.</p>

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	<p>On the other hand perhaps the amount given could be averaged out so that one saves ahead for more difficult times.</p> <p>8) In answer to the latter question, it would make sense (and less bureaucracy ) to include for items that the person might be likely to need or benefit from, and can obtain themselves from their own source to suit their individual need. However this need not include expensive 'one-off' items. i am amazed by how many charities offer wheelchairs or use of one. I have tried many aids for my condition, some of which are invaluable, but most, I have to say, have been overpriced and not very helpful. Some (such as my stick) are by far the best from a professional source i.e. in my case the Rheumatic Hospital. This was provided free by them. I definitely think that use of a wheelchair should not be taken into account as a criteria for extra money. Anyone can use a wheelchair - it doesn't describe their health or mobility. Although I sometimes would love to use a wheelchair when amongst people, because of my frailty and difficulty walking, I cannot because the affect (of compression) on my spine which would be worse for sitting. Thus the use of a wheelchair is no indication of the degree of my disability.</p> <p>9) In response to making the claim form easier : please make it shorter! Most of us have compromising conditions...filling this form in is EXHAUSTING! At present it can be anxiety-producing and maybe too, depressing, as it reminds one of all one's limitations, and the fact that these are here to stay. I wonder whether, if one has a potentially qualifying condition (such as Marfan Syndrome) and one's GP and/or Consultant supports the application...there might be sections of the form that one could be 'excused'? Perhaps the emphasis of the questions could be reversed? e.g. instead of what one can't do, perhaps ask what can one do. For example, How long can you use a computer without it causing you pain ? (Obviously I can use one, but what the reader doesn't know is how often i am having to lie down and rest). Or, what can you do in the garden (or house)? etc. This could be followed by, 'What could you do in the garden (house) if you had help ? And maybe more of the questions requiring answers in your own words or expression, and less of ticking prescribed boxes. With regard to the second question -improving information - this puzzles me, as it seems quite clear to me, what the benefit is, and who should qualify. Perhaps though this is because i have a definite long-term incurable condition ? I feel one's GP should be part of the picture, and perhaps suggest it, and/or explain it. I wasn't even aware DLA existed until 2003/4. Perhaps it will be easier once the Universal Credit comes into being ?</p> <p>10) i think this is a difficult area, mainly because there is no guarantee that there is anyone (if one lives alone as I do) who witnesses oneself on the worst days. My doctor rarely if ever sees my migraines as i am unable to move, and i do not like to call him out when I know what it is. I think all that can be done to encourage a one-to-one relationship with ONE GP (who then truly gets to know one) should be done. Then this is probably one of the best people to provide this assessment, as would a Consultant's report -again if the Consultant knew one, - so often now, one sees 'one of the team', which for a rare disease, is sometimes inadequate (by their own admission). However, this assessment could also be supplemented authoritatively by another health professional - my occupational therapist and my osteopath would both be well placed to do so. I feel this should be left optional -the client is probably the one who can judge who knows them best. There are also sometimes difficult circumstances. for example, my GP who had known me for 9 years and was taking an interest in getting to the bottom of my case, suddenly committed suicide. At that time no-one knew me, and I was ill and weak, completely unsupported. What happened in the event of my first application, was that a Doctor from DLA visited me for at least an hour in my home -and this was the best thing. A follow-up visit from another DLA Doctor the following year confirmed my 'indefinite' status.</p>

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	<p>I felt both doctors were objective, fair, thorough, and compassionate. I felt very fairly dealt with, and can only recommend my experience.</p> <p>I realize this may be expensive though.</p> <p>11) I would welcome a face-to-face meeting with a health professional in my own home if they were comprehensively informed as to my condition, and qualified to make a judgement that took into account the whole picture.</p> <p>A rare, and rarely encountered condition such as Marfans or any HCTD (Heritable Connective Tissue Disorder) might well present difficulties to a health professional, as the symptoms are difficult to analyse even by a specialist.</p> <p>In a case such as mine, I believe the Consultant's and GP's reports should carry weight, and also there there should be at least 2 levels of appeal process available should it be deemed by the healthcare professional that the Allowance suddenly be revoked.</p> <p>It would cause me considerable stress for a discussion to be conducted at some venue outside my home.</p> <p>Also, in my own home, it can be visibly seen how i live, and how I have to live.</p> <p>I think the visit should be conducted in the spirit of setting out to help someone, and showing concern for them - not in the spirit of 'inspecting' the client, possibly in an unsympathetic way.</p> <p>Most disabled people are in a genuinely vulnerable position, especially when one lives alone, and a home visit requires mutual respect from both sides.</p> <p>12) If the client was initially awarded the Allowance after a knowledgeable Doctor's or Consultant's assessment, and also it was said to be for an indefinite time, the reviews should be as infrequent and as simple as possible.</p> <p>Possibly if the client sent in twice-yearly 'updates' voluntarily (backed up if necessary by their doctor) the frequency of the reviews could also be reduced.</p> <p>Computerization should make this a possibility.</p> <p>yes, there probably should be different types of review, or different sections within the review, much of which could be exempted from, (as said earlier) if possible.</p> <p>Older people, nearing or after retirement age should be subject to fewer reviews, if any, for incurable conditions.</p> <p>Reviews must be expensive and laborious to administer...they are certainly to be dreaded by the client. It would be good if the character of the new review could change this.</p> <p>The suggestion for voluntary updates might be one way forward.</p> <p>13) I would think that it is undeniable that a probable common reason for not reporting changes (for the better) is the dread of the Allowance being abruptly and completely stopped, only for the improvement in condition of the client's illness to reverse again, and for them to be left without help when they most need it.</p> <p>My suggestion is to have 4 different levels or zones of benefit, with each only gradually different from the next, and to allow and/or encourage the client to voluntarily switch between the levels, knowing that they would still receive some benefit, and that also it would be both simple and quick to revert to the previous standing when or if this became necessary, as they would still be fully registered.</p> <p>Thus they would not have to dread the scenario of being cut adrift and completely unsupported.</p> <p>If the level change was to a more serious or severe level, this could be backed up by evidence from a doctor if and when deemed necessary.</p> <p>Such a system, I would hope, should be achievable with computers in the 21st century.</p> <p>?) I am more than content for my assessments to be shared across departments where ever necessary - anything to reduce the stress of form-filling, and further assessment.</p> <p>I'm not sure if those involved in doing the assessments know how traumatic they can be for the client...most especially when one is already struggling with formidable levels of incurable pain on a daily basis. Stress really does affect one's well-being, and ability to cope.</p> <p>Of course they have to be done, and done fairly, but anything that can streamline and minimize their impact would be welcome.</p> <p>However, one would also hope that confidentiality was rigorously upheld, and all data protected.</p> <p>?) i fear requirement might be counter-productive. Those unable to respond to advice or receive support, might just pay lip-service to the requirement.</p> <p>I think genuinely offering it, and perhaps asking a question as to whether people are aware it is there would be good.</p>

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	<p>Perhaps too it wouldn't hurt to have some feedback, or 'real life stories' from people who actually have been helped by accessing such advice/support.</p> <p>?) I think it would be helpful to have part of the DWP website dedicated to the Personal Allowance -and to be able to find here -clearly and simply - links to Disability groups (perhaps 'Enable'), as well as to support groups for the different conditions people suffer from.</p> <p>These support groups in themselves usually provide specific advice, as well as further relevant links.</p> <p>I think it is invaluable to know how other people live with and manage the condition one suffers with, even more so when the condition is rare and therefore not common in one's locality, - and this is a great advance now we have the internet making this more feasible. Self-help is good as it encourages self-responsibility. It would be good for the DWP site to encourage and support this.</p> <p>However, as a note of caution, I would say that those with a serious condition usually know only too well what it is like to be deluged with well-meaning but inappropriate advice, which can end up confusing and depressing.</p> <p>?) I think it would be very serious, and prove to be a real disadvantage, a retrograde step. However, if one only receives DLA for mental health issues and one's mobility isn't impaired, I'm not sure that this should automatically be a passport to a Blue Badge for instance.</p> <p>There is already a lot of resentment from 'the ordinary public' towards Blue badge holders if they see you get out of a Blue Badge space and (to their uninformed eyes) you 'look normal'.</p> <p>(I suspect this is because there is a lot of abuse of Blue Badge only spaces -very frequently taken up people without the Badge.)</p> <p>Again, I find myself wishing that the public were more aware of the fact that there are serious heart conditions which are not immediately visible to the naked eye.</p> <p>?) I would suggest that perhaps it be considered how much of help awarded on behalf of a child actually does improve the quality of life for that child - rather than mostly helping the parent.</p> <p>I know helping the parent would usually help the child, but not always. I think the child should have a voice in this, and be heard, however odd what they try and say.</p> <p>I had a seriously disabled brother, who died aged 17, and I stayed at home in order that I could help be an advocate for him. It is not easy for a disabled child to be so very dependent on a parent. Perhaps one of the things a Personal Independence Payment could do for a child would be to help find for them their own personal advocate and friend outside of their parent.</p> <p>?) It has been very important and useful for the DLA to act as a 'passport'.</p> <p>It has saved a lot of stress and having to prove one's disability all over again -which is never something one would wish to do.</p> <p>The passport to the Blue Badge was fairly easy, and this is invaluable for other things too. Also, the Warm Front Grant was immediately given at the full rate.(I believe £2,700).</p> <p>However, this was of little advantage to me, as the company involved only spent £600-700 and less than 2 hours on window/door cracks, and kept the rest. (The loft was already done, and wall insulation wasn't possible). When I asked for some of it towards double glazing of 2 large windows, which was really what was needed -and still is, it's a very cold room - I was refused.</p> <p>I think this is unsatisfactory, and wonder how often this has happened?</p> <p>d really help if the DLA 'passport' was used in conjunction with applying for Housing Benefit. It would give an authentic indication to the Housing Department that one's special housing needs were genuine.</p> <p>I wonder too whether a Personal Independence Allowance might be a 'passport' when applying to an Energy Company for a special high usage rate?</p> <p>?) The Allowance as it is at present mostly funds my aids and adaptations.</p> <p>It would seem to be a good idea to be able to use the Personal Allowance as a form of loan-to-onself for one-off items. i.e. for a very expensive item the money could be forwarded, and then taken back month by month- as a loan would be.</p> <p>I also think the DWP website that deals with the Allowance could have links to other organizations and the numerous charities that might help with such one-off items.</p> <p>?) The DLA is, at the moment, not just very important to myself and a number of other Marfans I know, but vital.</p>

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	<p>Extra money really does make a difference, as does being in charge of how it is best used. Since my diagnosis, and the consequent award of DLA, my health has stabilized, and I have been able to cope with a lot, even the double involvement of my sister and mother. However, apart from having the funds to pay for extra help and care, there is also the important issue of finding the appropriate help in the first place.</p> <p>This is far from easy, and I wonder whether there is anything that the DWP could develop via its website to aid in this matter?</p> <p>If people have the help they need they can definitely lead happier lives where they can contribute more, and be less of a burden - which I can't believe anyone truly would want to be.</p> <p>Is there anything that could be done via DWP, without costing very much, to help disabled people connect up with those who could help them?</p> <p>Perhaps there could be something like an independent forum/agency which could connect up people who needed help with people who could offer it, and DLA or the new Allowance could be used as a 'passport' to enrol ?</p> <p>Helpers or carers need above all to be trustworthy, and hopefully patient and kind and empathetic, certainly not brusque.</p> <p>They also need to have adequate comprehension of English, a good sense of hygiene, and ideally, be available long-term.</p> <p>People who are older (and have time to spare), or who have experienced health difficulties themselves may be ideally placed to offer help to others.</p> <p>I would gladly offer to help set-up a website to register potential helpers. I'm sure there are other older, experienced people in my position who could also help voluntarily to run such a site. It would be a form a self-help really.</p> <p>The site could develop so that descriptions of their experience could be given by the disabled people, to help future compatible pairings.</p> <p>Indeed people with 'opposite' types of disability could help each other..a sort of skills exchange between people with disabilities... or people with the opposite and complementary abilities.</p> <p>None of this in itself should cost more money..but it could lead to a better utilization of money already being granted.</p> <p>I feel this suggestion does relate to the proposals as outlined - as it is addressing the quality of life, independence, and positive contribution that people with long-term disabilities can give and have, - which does depend, to a certain extent upon extra money, but also upon other things being available and accessible to them.</p> <p>?) the new proposals would seem to be broadly fair.</p> <p>There is now more awareness of, and therefore avoidance of, possible prejudice in known areas of issues (gender, race, orientation, and disability, also ageism).</p> <p>I do wonder though whether a more subtle form of prejudice is emerging, expressed in other areas ?</p> <p>For example I believe there is often resentment expressed, - not towards people who are disabled (as in broken limb, wheelchair user etc) - but towards people who are ill.</p> <p>There is at times an attitude towards illness that is intolerant of tiredness, or lack of stamina or strength an ill person may unavoidably have.</p> <p>As if : 'it's ok to be disabled if you get out and go to discos and take part in the para-olympics' but not ok if you are frail and weak and limited by this weakness.</p> <p>Sometimes too there is an unfairly held assumption that pain is 'all in the mind', and that 'positive thinking' and sheer willpower would overcome these problems of tiredness and severe chronic pain that the ill person may be suffering from.</p> <p>Some people are too ready to believe that some other people are feigning illness or are unnecessarily self-absorbed with it.</p> <p>I feel this attitude, as with the source of many prejudices, is born from ignorance...ignorance about what it is actually like to have an incurable and/or terminal condition that makes you ill.</p> <p>Anyone truly in such an unfortunate position knows only too well the value of positive thinking and using your will to overcome challenges on a daily basis.</p> <p>If accused of not doing so, (i.e. 'you're being negative' ) this at least doubles the hurt and loneliness of being in such a position.</p> <p>I hope this makes sense. It is a plea simply for more kindness in society, towards those</p>

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	<p>who are frail and vulnerable - who are not bouncing with 'normal' energy.</p> <p>Indeed, it could include those who are suffering from depression or mental health issues (perhaps after a serious breakdown when people are very vulnerable)...where it is not unknown for some people around them to be impatient, irritated that the person concerned doesn't 'snap out it' and 'pull their weight'.</p> <p>It needs to be understood that some people actually cannot....but would have done if they could.</p> <p>It needs to be understood - generally, in society -that being in pain 24/7 affects one severely, and diminishes one's potential.</p> <p>However, it also isn't desirable that people make themselves appear more ill or emphasize their incapacity in order to receive more money.</p> <p>I do realize there is a balance to be struck.</p> <p>I think that the way in which the DWP proceeds with the form and wording(s) of such things as assessments can really help with influencing these public attitudes to the good.</p>
ONLINE472	<p>1) people with learning disabilities face a wide and varied number of difficulties. Many have difficulties getting about, particularly using public transport. Consequently they have to use other forms which are extremely expensive such as taxi's. They cannot afford this, so a large proportion who live independently have very limited social lives. Many have communication difficulties, struggling to read letters, fill in forms and manage daily matters. Many of the older generation we work with need support to realise they can arrange their own social lives and to learn these skills.</p> <p>3) We work with people with learning disabilities and their greatest costs are getting support to be able to lead an independent life. Many find public transport difficult and won't go out in the dark so have to use expensive taxi's. The costs of these are unmanageable for many so consequently they don't go out much. Many people have difficulties with cooking so buy ready meals which cost more than preparing your own. People often spend more time at home as they don't work or go out much so their utility bills are more. many people are still using keys and cards to pay for their gas and electricity which is more expensive anyway.</p> <p>Some people with learning disabilities will have addition behavioural difficulties which result in additional clothing, washing, food etc</p> <p>Many people who receive support in the community to access venues and activities have to pay for the carers meal, entrance, ticket etc so activities can cost double.</p> <p>4) I do not think there will be much difference as many people understand the three rates already.</p> <p>5) Claims should be based on the needs and circumstances of the individual. How this is assessed is my main concern as most health professionals have no understanding of people with a learning disability. Our clients are constantly being turned down due DLA because a GP has written a report which shows no understanding or knowledge of a persons difficulties due to their learning disability. It is right that the effect of a condition should be assessed rather than the condition itself.</p> <p>6) It is essential that any assessment is carried out by people who have a knowledge of the condition. General medical professionals have almost no knowledge of people with learning disabilities and consequently their assessment is flawed. GP's regularly provide reports which give a false impression of an individual's abilities because they only know about a person's health conditions. People with learning disabilities do not necessarily have any health conditions so GP's are not the best people to provide information for those who do not have a health condition but are disabled.</p> <p>It is a good idea that people are assessed on the impact their disability has on their life rather than the disability itself. Many people's learning disability has a huge impact on their life but this is not recognised currently by DLA e.g someone who cannot plan a journey or</p>

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	<p>go anywhere unknown has their life hugely limited.  The main activities people we work with feel are essential are:-  Planning and making journeys  fending for themselves such as cooking, cleaning household chores.  COmmunication - talking and understanding, letters, forms and using the phone.  Mental well being  Looking after themselves - health issues, personal care  10) If you insist on general health care professionals carrying out the assessment then for many people with learning dsiabilities the situation will get worse. Having a learning disability does not mean that you have a health condition at all and there is an ignorance of people with a learning disability within the health profession. I am a registered nurse for people with LD and regularly see poor treatment for people with LD in hospitals or accessing their GP's.</p>
ONLINE473	<p>1) Access to Transport  Doing things they want  Lack of self confidence  Feeling worthless  Support  Having little/no money  The cost of paying for two people if i need to take my support worker with me to help me  No work around for people with disabilities  I fall over easily and get frightened  Discrimination  Access to places/people</p> <p>2) All of it  People who are disabled should get more money than people who have a very slight disability  The standard of living for people with disabilities needs to improve NOT reduce</p> <p>3) Support Staff  Holiday abroad (special)  Help with clothes (extra wear and tear)  Help to go to social outings  Help to visit friends  Help towards spectacles  Help towards special footwear  Specialist equipment (I am blind)  Specialist medical equipment (I have very complex needs)  Transport</p> <p>4) Think it will be harder to understand. Who will help us fill in these forms. Will cause confusion  I thought DLA was like that anyway. There should be a mental and a physical element  There is a big difference between someone needing a little bit of support once or twicw a week and somone needing 24 hour support. They should keep a middle rate for others who need support maybe on a daily basis  Two amonuts confuses it  No to first part of question  Yes to second part of question</p> <p>5) Part1 - Yes  Part2 - Depends  Yes part 1 It should be based on individual need and those with greater should get more  Yes if your condition or disability affects your quality of life</p> <p>6) Proper Assessment with person  Make the Form easier to understand and make the criteria easier to understand. You need money to enable you to live an independent life but activities are same as for everybody  People receiving information about their rights in an accessible format and caerers understanding benefits. Healthy diet, keeping clean, carers being properly trained and having the right information to support you</p>

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	<p>Support to fill out forms if needed. Feeling valued, accepted, included in society, doing whatever i want to do</p> <p>7) Having more of an understanding of health conditions Should be reviewed regularly and people need to know to let others know when their needs change Their should be an accessible sytem to review that everyone can access Six monthly reviews, user friendly forms that everyone can understand By filling the form correctly and understanding the questions</p> <p>8) Yes If a person needs an aid they should get it. Ensure that a person gets the right aid/adaptation for them Yes because the aids and adaptations are important to the individual. Anything that helps them be as independent as possible and live their lives as they wish should be provided</p> <p>Part1 Yes Part2 All Part3 Yes if have them but No if they don't have aid/adaptation</p> <p>9) Clear questions NOT long confusing ones On the News, on audio, DVD, letter in plain english, hold meetings about it. Send people easy read information Specialist Benefit Advisors. Having Officers who can help. Job Centre staff should know and be able to give good advice Simplify the language, including the guidelines. Ensure they are accessible to everyone, TV Adverts, Newspapers, GP Surgeries Easy to Read, pictures, keep it short, language, e mail, letters, meetings Help to understand it, Public Meetings</p> <p>10) The Benefits Agency, DVD,Letter or Telephone Call The person themselves, carers, friends and family,Advocates, GP, Social Worker,all the people around that person. Assessment of Health Needs, information from the person, their Key Worker, GP,Health Professionals, Family and Friends Medical information, Daily Living Skills, Abilities Psychiatrist. Asking the right questions The person who needs it</p> <p>11) A bad thing would be if we can't do the things we want to do Make an appointment Independent person, person they know well and trust. Always in their own surroundings. Good thing - full and true assessment Bad thing - all needs not properly gathered If there is no need for change then there is no need to assess If the person has mental health needs they may not feel able to talk to people other than those who they trust and may not acknowledge their full disability, any independent person should be mental health trained</p> <p>12) A booklet easy to read Part2 Yes Only if need arises for some people there should be life long awards</p> <p>13) By making these questions more understandable, by giving examples Produce Leaflets on the changes in DLA and what people need to do ?) I think your plans are very horrible, your plans are NOT right We cannot manage now to have a good life like people without a disability please increase DLA Some of the questions you have asked in this consultation seem odd for people with a disability or special needs to understand and answer ?) If assessed as entitled for benefits it should make no difference whatever you are ?) Leave our old DLA alone it is very useful If people did not automatically get help from other benefits, services they would NOT have quality of life, they would feel worthless They would not be able to get out and about or keep warm on their DLA alone and this would affect their well-being No Blue Badge, Bus Pass would limit my access to my local community and restrict me joining in with the rest of the community. I would be isolated and that's wrong ?) Local Authority Grant or their own money if they are able when a grant is not available. If they don't have money they don't get aid or adaptation</p>

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	<p>Out of their allowance sometimes but won't be able to do this if DLA reduced or stopped  The wait for aids and adaptations from Local Authority can be very long and badly affect a persons independence whilst waiting  ?) Put all information on one system  Medical Records, Name Address, contact details, NI number, Bank details etc  Information about your disabilities  ?) Short easy forms, well publicised  The more information available the better  Citizens Advice Bureau, Job Centre Plus  ?) These Forms should be made easy for families.  Children between the ages of 13-19 need more help than adults  ?) Very badly affect people's lives.  People with a disability should get more help not less because they face discrimination by this government</p>
ONLINE474	<p>1) The main barrier is getting around. For example, as a high-level above-knee amputee I can walk short distances using an artificial limb and a stick but I walk much slower than I used to, and walking is painful. This means I rely on my adapted car for even very short journeys, for example to pick my daughter up from the local school, and to get to the local shops. I also use my adapted car to get to work, and to drive to jobs at work (which I would previously have been able to walk to). Using public transport is not possible for me because of where I live - I am unable to walk as far as the nearest bus stop. Despite these difficulties, I - along with millions of other disabled people - battle through these barriers every day without complaining to make sure I go to work, pay my taxes, look after my daughter etc.</p> <p>2) The option to use the DLA payment to pay for an adapted car on the Motability scheme should stay the same. This is a lifeline for me and others like me. It means I can go to work, look after my daughter the same as anyone else - despite the extra costs involved in getting and maintaining an adapted car.</p> <p>The way claims are assessed using my own GP and/or medical professional - who actually knows the challenges I face should stay the same. I do not want to be repeatedly assessed by an outsider who knows nothing about my situation.</p> <p>The frequency of assessments should stay the same. I am concerned by the proposal to have more frequent and repeated assessments. It is intrusive enough to go through assessments without the prospect of having them more frequently. I have always kept the department up to date with changes in my condition. Why not send out an annual declaration for people to sign to say their condition is unchanged/changed if you are worried some people don't do this?</p> <p>3) Transport. I need to use an adapted car to get around. It has to be an automatic car with left foot accelerator. The cost of automatic cars on the open market is far higher than manual cars. I can only afford my adapted car via the Motability scheme, paid for by DVLA. My adapted car means I can work, take my daughter to school etc. I cannot use public transport because the nearest bus stop is too far from my house and my place of work.</p> <p>6) Getting around with reasonable ease and within a reasonable time. For example, being able to travel to work in an adapted car rather than having to perhaps get a taxi or walking very slowly and painfully to a bus stop that is too far from home/work. This is a vital factor in enabling disabled people to have full and active lives, particularly when working, because everyday activities - such as washing, cooking etc already take a much longer length of time and effort than they do for able-bodied people.</p> <p>8) It is vital to understand that whilst aids and adaptations (eg prosthetic limbs, wheelchairs, sticks, crutches) undoubtedly help me get around - they do not eliminate the difficulty, pain and time-consuming nature of doing so. Assessments should not assume that because a person may be able to get from A to B using limbs/wheelchairs that this means there are no extra costs/health implications from doing so. For example, as an amputee - walking causes muscle fatigue and pain, and skin sores which mean I may not be able to wear my limb the following day. Using adaptations should NOT be viewed as equal to getting around as an able-bodied person does. It is a common misconception (and one which I held myself before I became disabled) that amputees get fitted with a limb and walk off into the sunset. This is NOT the case. An amputee goes through many different limb fittings and will spend time using crutches, wheelchairs, sticks etc. As with many disabilities, some days it is easier to get around than others. I am concerned that, by</p>

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	<p>putting more emphasis on the aids and adaptations that disabled people use, (and not considering the effort and pain/discomfort that goes into using them) the effect may be to disincentivize disabled people from using them to get the most out of their lives. For example, would it be better to stop using an artificial limb and retain a Motability car so that I can at least get to work, than to be housebound with my limb on, unable to drive a car/get to the bus stop? I feel very strongly that someone who has put a lot of effort into their rehabilitation, by using an aid or adaptation, such as a prosthetic limb or wheelchair, should not be penalised financially for doing so - because the additional costs, inconvenience and physical challenges of getting around are still there.</p> <p>10) A GP or healthcare professional (such as prosthetist) or work colleague (for example your manager) who is nominated by the disabled person because they feel that person most understands their condition and impact on daily life and work.</p> <p>11) Why is this necessary? This would seem to create extra costs when all the information needed is already available via medical records. If you need confirmation of a condition, eg an amputation or MS - why can't you ask the person's GP. This would cut down on administration costs and the costs of employing an additional 'healthcare professional' to carry out all these face-to-face meetings. The person doing the assessment cannot ascertain the long-term challenges faced by a disabled person during a one-off meeting, nor can they appreciate daily fluctuations in a person's condition.</p> <p>Disabled people often face a large number of medical appointments in their daily lives anyway, so to add another one is unnecessary and a waste of public money.</p> <p>12) I am concerned by the proposal to have repeated assessments. Why can we not inform the department of changes to circumstance via letter or phone call, as is done currently. Repeated medical assessments are intrusive, time-consuming, stressful and unnecessary.</p> <p>13) What about an annual letter to sign, confirming circumstances remain unchanged - with a space to say if there are changes? Part of the problem may lie with your own departmental staff in my experience - I informed the department of a change in circumstances, stating I probably needed a lower level of payment three times by phone, and backed it up with a letter - but my payment didn't get changed until I got reassessed much later. Perhaps you need to concentrate efforts on training your staff and introducing more responsive internal administrative systems.</p> <p>1) Access to Transport  Doing things they want  Lack of self confidence  Feeling worthless  Support  Having little/no money  The cost of paying for two people if i need to take my support worker with me to help me  No work around for people with disabilities  I fall over easily and get frightened  Discrimination  Access to places/people</p> <p>2) All of it  People who are disabled should get more money than people who have a very slight disability  The standard of living for people with disabilities needs to improve NOT reduce</p> <p>3) Support Staff  Holiday abroad (special)  Help with clothes (extra wear and tear)  Help to go to social outings  Help to visit friends  Help towards spectacles  Help towards special footwear  Specialist equipment (I am blind)  Specialist medical equipment (I have very complex needs)  Transport</p> <p>4) Think it will be harder to understand. Who will help us fill in these forms. Will cause confusion  I thought DLA was like that anyway. There should be a mental and a physical element</p>

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	<p>There is a big difference between someone needing a little bit of support once or twice a week and someone needing 24 hour support. They should keep a middle rate for others who need support maybe on a daily basis</p> <p>Two amounts confuses it</p> <p>No to first part of question</p> <p>Yes to second part of question</p> <p>5) Part1 - Yes</p> <p>Part2 - Depends</p> <p>Yes part 1 It should be based on individual need and those with greater need should get more</p> <p>Yes if your condition or disability affects your quality of life</p> <p>6) Proper Assessment with person</p> <p>Make the Form easier to understand and make the criteria easier to understand. You need money to enable you to live an independent life but activities are same as for everybody</p> <p>People receiving information about their rights in an accessible format and carers understanding benefits. Healthy diet, keeping clean, carers being properly trained and having the right information to support you</p> <p>Support to fill out forms if needed. Feeling valued, accepted, included in society, doing whatever i want to do</p> <p>7) Having more of an understanding of health conditions</p> <p>Should be reviewed regularly and people need to know to let others know when their needs change</p> <p>There should be an accessible system to review that everyone can access</p> <p>Six monthly reviews, user friendly forms that everyone can understand</p> <p>By filling the form correctly and understanding the questions</p> <p>8) Yes</p> <p>If a person needs an aid they should get it. Ensure that a person gets the right aid/adaptation for them</p> <p>Yes because the aids and adaptations are important to the individual. Anything that helps them be as independent as possible and live their lives as they wish should be provided</p> <p>Part1 Yes</p> <p>Part2 All</p> <p>Part3 Yes if have them but No if they don't have aid/adaptation</p> <p>9) Clear questions NOT long confusing ones</p> <p>On the News, on audio, DVD, letter in plain English, hold meetings about it. Send people easy read information</p> <p>Specialist Benefit Advisors. Having Officers who can help. Job Centre staff should know and be able to give good advice</p> <p>Simplify the language, including the guidelines. Ensure they are accessible to everyone, TV Adverts, Newspapers, GP Surgeries</p> <p>Easy to Read, pictures, keep it short, language, e mail, letters, meetings</p> <p>Help to understand it, Public Meetings</p> <p>10) The Benefits Agency, DVD, Letter or Telephone Call</p> <p>The person themselves, carers, friends and family, Advocates, GP, Social Worker, all the people around that person. Assessment of Health Needs, information from the person, their Key Worker, GP, Health Professionals, Family and Friends</p> <p>Medical information, Daily Living Skills, Abilities</p> <p>Psychiatrist. Asking the right questions</p> <p>The person who needs it</p> <p>11) A bad thing would be if we can't do the things we want to do</p> <p>Make an appointment</p> <p>Independent person, person they know well and trust. Always in their own surroundings.</p> <p>Good thing - full and true assessment</p> <p>Bad thing - all needs not properly gathered</p> <p>If there is no need for change then there is no need to assess</p> <p>If the person has mental health needs they may not feel able to talk to people other than those who they trust and may not acknowledge their full disability, any independent person should be mental health trained</p> <p>12) A booklet easy to read</p> <p>Part2 Yes</p> <p>Only if need arises for some people there should be life long awards</p> <p>13) By making these questions more understandable, by giving examples</p>

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	<p>Produce Leaflets on the changes in DLA and what people need to do  ?) I think your plans are very horrible, your plans are NOT right  We cannot manage now to have a good life like people without a disability please increase DLA  Some of the questions you have asked in this consultation seem odd for people with a disability or special needs to understand and answer  ?) If assessed as entitled for benefits it should make no difference whatever you are  ?) Leave our old DLA alone it is very useful  If people did not automatically get help from other benefits, services they would NOT have quality of life, they would feel worthless  They would not be able to get out and about or keep warm on their DLA alone and this would affect their well-being  No Blue Badge, Bus Pass would limit my access to my local community and restrict me joining in with the rest of the community. I would be isolated and that's wrong  ?) Local Authority Grant or their own money if they are able when a grant is not available. If they don't have money they don't get aid or adaptation  Out of their allowance sometimes but won't be able to do this if DLA reduced or stopped  The wait for aids and adaptations from Local Authority can be very long and badly affect a persons independence whilst waiting  ?) Put all information on one system  Medical Records, Name Address, contact details, NI number, Bank details etc  Information about your disabilities  ?) Short easy forms, well publicised  The more information available the better  Citizens Advice Bureau, Job Centre Plus  ?) These Forms should be made easy for families.  Children between the ages of 13-19 need more help than adults  ?) Very badly affect people's lives.  People with a disability should get more help not less because they face discrimination by this government  ?) This would mean more assessments, more wasted public money, more time spent on various forms etc. It would endanger schemes that rely on the DLA - such as Motability - a scheme that has transformed the lives of thousands of disabled people.</p>
ONLINE475	<p>1) There are too many places to go for guidance and support - DWP, local authorities, social services, occupational therapists, GPs, health authorities, charities, CAB etc etc. Customers are confused about where to go for what. they frequently ring DWP for the Blue Badge scheme or adaptations to their home. When faced with this myriad of organisations, many give up and fail to get the help and support they need, which makes them unable to lead full and active lives.</p> <p>Prejudice and ignorance are still rife in many sectors, even those whose job it is to help disabled people. Those with mental health problems are particularly vulnerable in this area as they have no visible disability. I have had to intervene many times to educate staff about the problems faced by people with mental health problems. The general public will stop to help a blind person cross the road, when actually they are probably quite capable of managing it themselves. But will cross the road to avoid someone having a seizure or crying because they are lost or talking to themselves.</p> <p>A single source of advice and guidance is needed to signpost customers to the help they need. No doubt in the "big society" this will be down to the voluntary sector, but they do not have the resources. Have you ever tried to ring the CAB?? We have the IT capability to hold a central database of where to go for what. Not necessarily detailing everything available, but who has responsibility for each element.</p> <p>1) too many sources of help - central govt, local authorities, health authorities, charities, CAB, Welfare Rights. Disabled people don't understand what is available from where and get confused. After a while they give up in frustration. Staff in DWP also find it hard to signpost customers to the relevant source of help. Charities tend to be good at this, but their resources are severely limited. No single source of help and advice.</p> <p>2) automatic entitlement under certain circumstances. The deeming provisions make life easier for people at traumatic stages of their lives. Making them undergo further medical examinations will be demeaning and unnecessary. If someone has become a double</p>

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	<p>amputee or blind following an accident, the last thing they need, on top of coming to terms with a major life change, is a complex benefit system. The current rules allow us to implement benefit quickly and painlessly in these circumstances.</p> <p>3) It is the little things that add up. Shoes with velcro rather than laces, extra wear and tear on clothing, special cutlery and household implements, chunky pens, IT equipment, replacing things broken during everyday life due to falls etc. These things don't really come under the heading of personal care, but the lack of them makes life more difficult than it needs to be. Each person will need different things at different times, so it is hard to quantify. Claimants don't fit into neat categories or boxes.</p> <p>4) Having just 2 rates will be easier to administer, but may exclude some people who fall just short of the lowest rate, but still have additional costs related to their condition. I have frequently seen the lowest rate care component awarded at appeal, because the tribunal acknowledge the customer has some needs but they don't actually fit either of the criteria. Staff tend to call it the "consolation prize". The tribunal are trying to provide the customer with a means of defraying additional expenses. The lowest rate of mobility is a nonsense and extremely difficult to administer fairly, particularly in the case of children. Trying to decide what is above and beyond normal for a child of a certain age is an impossible task - it is far too subjective.</p> <p>Mobility should cover all aspects of getting about - with a lower and higher rate depending on the difficulties faced. However, the paper seems to be suggesting that where a wheelchair user is active and safely mobile in their chair, they would not qualify. We cannot compare them to someone who has full use of their legs. Yes they may get around very well, compete in sports, do DIY etc, but they will have more expenses than someone with the use of their legs. Wheelchairs are expensive to buy and maintain and each user needs one tailored to their specific needs and lifestyle which costs money. The same goes for amputees with false legs. Once they have adapted to life with prosthetic limbs the benefit is removed. this ignores the fact that they have additional expenses in terms of wear and tear on clothing, special shoes etc.</p> <p>5) yes - unless you want to repeat what has happened so far with DLA. If you want to keep costs down, deeming provisions are the best way to do it. Otherwise the whole thing becomes subjective again and leads to far more reconsiderations and appeals. There are many conditions that will result in additional expense for the disabled person. Where there is a single disabling condition, make it automatic and leave the multiple disabilities to be assessed. We have case law that has gradually identified more and more of these conditions - as long as the awards are time limited rather than indefinite, it will allow us to review them in line with new treatments and medical advances.</p> <p>6) Whatever financial support we provide, disabled people need to be able to regain and/or maintain their self esteem and feel like they are a useful part of society. In addition to being able to provide themselves with the basics of shelter, food and clothing to meet their particular needs, they also need to be able to engage in the world of work (if they are capable) and participate in some kind of social life. Physical disabilities can all too easily become mental disabilities as depression sets in when someone feels they are no longer a useful person.</p>
ONLINE476	<p>?) It is very important, keeping on being assessed and form filling would be never ending. But sometimes people are excluded from getting other help because they don't get a certain rate or component of DLA and some people chose not to claim at all yet are not abale to access certain support so it shouldn't be the only criteria for accessing further support.</p> <p>1) Usually, other peoples ignorance! It depends on the disability, some are invisible, cannot be seen yet have devastating effect on a persons life. Some will need a p.a. or carer with them all the time, others need an aid of some sort. It would seem that as soon as you mention disability the price is enormous, you can't just walk into any shop and find what you want. Some people like my daughter will never lead an independent life, she has too many complex needs, she is severely disabled. No assessment that only last an hour or two would be able to fully cover the extent of her needs.</p> <p>?) Endless form filling and assessment if it could not be used at all and by all involved. PIP shouldn't be the only criteria to access other services.</p> <p>2) There should still be the form to complete. My daughter has complex needs, she would not cooperate with an assessment, she has a severe learning disabilities and would not understand the assessment and it would put her under an awful lot of extra stress to be in</p>

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	<p>that situation, it would not be appropriate. We care for our daughter 24 hours a day, 7 days a week, most of what we do for her is automatic and routine, however much is way above and beyond what would be average for someone her age, it's only when you have time to sit down with the form that you realise quite how much extra you do. You can fill the form in, come back and read it again, add extras as you think of them, this is not possible in an assessment. What will be put in place for those incapable of understanding and participating fully in an assessment? How is an assessor without proper specialist medical doctorate training going to be able to assess someone with complex needs that is currently under 5 different consultants and 4 different therapists?</p> <p>3) For our daughter it's having to have her supervised on a 1:1 basis for all the time she is awake and for when she wakes at night. She can walk but falls regularly and has no sense of danger, she cannot operate a tv or kettle or make herself a meal. She needs to be cared for all the time, if we can't do it then someone else has to be paid to do that. Extra therapies that are not available on the NHS or have been recently cut, the cost of this for us has recently gone up. Mobility aids, costs of extra transport as she can't walk longer distances and can't see hazards in her way and has no road sense. Equipment gets broken and needs to be replaced, the wait for new stuff can incur extra costs or mean she is stuck indoors for some time. The costs of continence pads as those provided by the PCT are too few and not always the most appropriate, despite claims this has changed.</p> <p>?) I think it would be beneficial for departments to talk to each other and have access with permission to other assessments. But, this would have to be backed up by a vigorous complaints and appeals procedure.</p> <p>4) No, I think having the 3 levels of the care component works well. Where will the line be drawn between high and low rate? There's a big difference between someone who needs extra care for just a couple of hours a day and someone who cannot be left unsupervised at all during the day and the costs that are involved with this. I don't see how only having 2 levels will work.</p> <p>5) yes, for the most severely disabled.</p> <p>6) If you want to be fair and have equal rights for people with disabilities then everything that anybody else without the disability can do is an essential. I fail to see how one assessment can fully establish a person's needs and abilities, let alone the cost implication of having to pay assessors and the admin needed to back them up. A person with disabilities mobility need does not cease when they enter a home, they still have the right to independence, to be able to go out when they want, to visit family, this can be hugely expensive for someone in care. Also hospitals do not provide care, they just provide mainly for medical need. Nurses are under so much pressure they don't have the time to sit with patients and carry out their normal care routine, a high level of that person's care need will still be carried out by their normal carers. This is especially true for children, it is expected that a parent will stay and carry out normal care and therapy duties, it is ridiculous that DLA stops when a person goes into hospital.</p> <p>7) I don't see how it can, any more than a form could.</p>
ONLINE477	<p>8) Aids and adaptations should NOT be taken into account that includes prosthetic limbs, as without these a disabled person cannot function.</p> <p>A profiling bed can assist someone to independently get up in the morning, without this someone has to help. A wheelchair can get you from A-B but without you would remain in one place.</p> <p>It is a stupid idea to say that because someone uses some kind of aid they are less disabled than someone who uses none.</p>
ONLINE478	<p>1) A lot depends on the type of disability as stigmas still exist within society to the unseen disabilities and the mental disabilities.</p> <p>There are still access problems for wheelchair users, unfortunately this can still cause an issue in the workplace.</p> <p>There is also the potential for Employers to have an increase in their running costs were they to employ a person with a disability. Giving employers a grant to take on a disabled person may help the employer but does not guarantee the continued employment of that disabled person. Grants or concessions are usually for a fixed period once the period is up</p>

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	<p>the disabled person could find themselves to be out of work. For example local authority were filling job vacancy for fixed terms. Disabled people did fill some of these posts ; it can be argued that they gained experience in the work place which will look good on their C.V when seeking future employment. But the reality is very different to the vision.</p> <p>1) In getting disabled people who could work back into work the greatest problem to be overcome will be employers' attitudes to attendance management or simply put time off for sick leave or receiving or following up on medical treatment. In an age where resources are being roped in tightly even the Civil Service attendance management has little flexibility on time off for disabled people. This affects all disabled people and having watch was stated this morning on TV regarding access to a better Mental Health service for children i have concerns for those adults of working age and the obstacles that they have to tackle in the work place if they are lucky enough to find an employer who will take the risk and employ them. There are often other physical disabilities that have no visual symptoms such as ME/CFS that even some members of the Medical profession still struggle to accept as a severely disabling condition how is the pint scoring system going to impact on these types of illnesses where the disabled person can physically perform a number of activities but does not have the stamina/strength to hold down a job. This illness prevents the disabled leading a full and active and independent life what will become of them.</p> <p>2) The proposals for the new benefit indicate that the care element will be limited to two rates not as it is at the moment three rates. The lowest rate should remain in place but only for care needs for a significant portion of the day. The new provisions should not include the main meal test as the interpretation of these provisions have been stretched too far. I can be approached to explain further what i mean by this statement.</p> <p>2) There should still be three rates to the care component, reflecting "significant portion of the day", during the day and during the night.</p> <p>But the new legislation could also look at combining supervision care needs and attention needs with bodily functions and assistance with domestic chores. That way it will be a benefit that reflect the totality of care needs with aggregation not segregation of care needs. This will simplify some of the complexities of DLA.</p> <p>3) As I have previously stated travel costs, heating costs, clothing, but I should also add to that medication as not all disabled people receive free prescriptions, also diet can with some illnesses prove to be quite expensive. Extra expense is also incurred through higher insurance premiums, if they are lucky enough to be able to take an holiday, insurance premiums are increased dramatically often by as much as 2-3 hundred pounds and more.</p> <p>3) Travel costs when public transport is inaccessible. People who do not meet the legal criteria for the mobility may still have difficulties travelling on public transport, these people may only be able to travel by Taxi to appointments, if working to work, to social activities, this can prove to be expensive. Where the disabled person does not work and has to spend a lot of time at home fuel costs especially at today's rates can be a commodity that would be out of their reach if their income was to drop. Then there is clothing as only specific types of clothing, footwear as specific types may be required. Also aids and adaptations, not everyone can obtain aids from their Social Services Departments and we are already been given indications that these frontline services are going to bear the brunt of the "spending cuts".</p> <p>4) The disabled who mainly need help with getting up, washing, dressing, dealing with correspondence, and going to bed at night will find that they are not going to get help. This is what happens now with the elderly who apply for attendance allowance, which should be amended to include significant portion of the day. But that goes against the grain of the actual intention of the Benefits overhaul of DLA which is to cut costs.</p> <p>4) This has been dealt with to some extent at my response to Question 2. The three rates for care should remain with the removal of the "main meal test". That will ensure appropriate levels of support for care needs. Many people need help with care which concentrates on assistance in the morning, washing, dressing etc. To reduce to two rates it looks as if entitlement will be satisfied where attention is required frequently throughout the day and repeatedly or for prolonged periods at night; or where the supervision provisions (if they still exist) are met during the day and at night. The disadvantages are the same as now, deciding who fits where. But the disadvantages to the disabled will be greater if there is only one rate, this should be an advantage to the public purse as it would be a cost saving exercise at the expense of disabled people. I do not believe that having only two rates will make it easier to administer, it will reduce the cost as less people will qualify. But</p>

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	<p>appeals are likely to increase initially. Is the cost of this new benefit an expensive cost saving exercise at the detriment of the disabled. What are the disability organisations concerns. Instead of introducing a new benefit and the costs incurred with that would it be less expensive to overhaul the present provisions.</p> <p>5) Entitlement should be based on individuals needs there should be no automatic right. But the "special rules" should remain for the terminally ill.</p> <p>5) This maybe an harder subject to tackle as some specific disabilities already have this automatic entitlement. To try and remove that automatic entitlement to those who already is likely to meet with opposition from those disabled people and the organisations who support people with those disabilities. But to treat everyone young or old equally then equal opportunity should be given to everyone; it is right to treat everyone the same way and assess all claims on the basis of individual needs and circumstances.</p> <p>6) Engaging in social activities have a positive impact on the mind, many disabilities give rise to negative thought thus leading to the risk of suicidal thoughts. People coming to terms with physical disability often suffer from mental health difficulties that are brought about by the continuous struggle of living with disability. For a disabled person to live as full a life as possible they ought to be helped and encouraged where possible to engage in social activity. As the spending cuts hit home on front line services the disabled may be having to pay for care needs such as washing, dressing, dealing with correspondence, getting to appointments and some domestic chores such as cleaning, laundry, shopping activities that have in the past been undertaken by Social Services. Help with these activities was outside the boundaries of disability living allowance but are activities essential to daily living, though each activity may not be undertaken everyday. These activities should be included in the new assessment. Mobility issues should also be a priority as the ability to undertake activities outside the home are an essential part of living a full and independent life. Employers need to look at their policies and procedures to ensure the disabled in their employment are fully catered for. And Employers attitudes to giving the disabled jobs needs to be addressed.</p> <p>6) I have previously suggested leaving out the "main meal test" when the new benefit is legislated for however, though cooking is in itself not a bodily function, eating and digesting food and drink is. If the disability itself prevents the disabled person cooking and preparing food the new benefit legislation should include provision for those who are unable to provide themselves with this essential necessity. Engaging in social activities have a positive impact on the mind, many disabilities give rise to negative thought thus leading to the risk of suicidal thoughts. People coming to terms with physical disability often suffer from mental health difficulties that are brought about by the continuous struggle of living with disability. For a disabled person to live as full a life as possible they ought to be helped and encouraged where possible to engage in social activity. 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If the evidence is not there it can prove costly to obtain further evidence. It maybe the case that everyone claiming the new benefit has to have a medical. But such examinations also have their problems; this is demonstrated in some of the appeals that are pursued which highlight problems in that medical evidence. That maybe because the correct evidence has not been obtained or is inconsistent or contains contrary evidence to other available medical evidence. It is a matter of asking the correct questions in sufficient detail to obtain the information regarding the extent of any fluctuations or variability of the disability. Evidence gathering must and does play a major part in getting the decision right the first time.</p> <p>8) I do not think that aids and adaptations should be taken into account because they do not remove the disability that remains. The disabled person still has to cope with the difficulties brought about by the disability and some aids may only be used at a physical or</p>

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	<p>mental cost or discomfort to the individual. For example an amputee who is dependant on a prosthesis. The prosthesis does not replace the lost limb the person is left with the physical and mental scarring for the rest of their life. Why treat them unfairly because they have had the guts to face up to their loss and tackle it. Should they be punished financially because of their positive attitude.</p> <p>9) In trying to get it righ the first time around as I have suggested in my previous response it maybe necessary to have a health care professional undertake an examination. It maybe better if the disabled person is helped to fill in the claim form by a member of staff working on the front line, i.e JobCentre staff or at the time the disability is diagnosed by a member of an organisation that is involved with the type of disability diagnosed. There is no single universal way for obtaining the evidence other than the claim form which means sufficient appropriate questions are essential. It is tge completion of the forms where help is often required and that help would be better if it is provided by someone who understands the requirements of the benefit and the relevance of the evidence. In the first instance where a new illness is diagnosed maybe a referral by the disabled person's GP at the consent of their patient. The disabled person could be contacted and help organised to complete the form should it be required by the disabled person. A lot of what happens with the Disability and welfare Rights organisations now will move forward to the new benefit. Whatever is decided will be as it is now governed by cost this will restrict the manner in which the information about the new benifit is given to the public. THE internet is probably the best place to start, leaflets been distributed as now to medical organistions GP Practices, NHS Trusts waiting rooms,libraries the list is not exhaustive.</p> <p>10) The medical professionals who treat the claimant and who fully understand the disability and the consequences of living with the disability. For example look how long it has taken for ME/CFS to be accepted as an illness that has seriously debilitating consequences yet some doctors who are not familiar with this disability still do not understand the extent of the impact of the symptoms of this illness on the person.</p> <p>11) The benefits are that clinical findings can be made; but the problem with this process is where the clinical findings do not indicate disability and there is still a very serious disability present; it is just unseen to the person undertaking the examination. Mental health difficulties, problems with behaviour, problems with exhaustion, problems with muscle pain and with bone pain and with internal organs. This is where the doctor or nurse who knows the person best and knows the consequences of the disability is the person best placed to give the information. Often the person's partner or family if totally open and credible can give a better insight on the impact of the disability on the disabled person.</p> <p>12) The criteria should include the type of disability, the extent of dysfunction, the treatment, the prognosis, and the age of the disabled person.</p> <p>There are some medical conditions that will not improve over time the reviews on these can and should be limited. But reviews still need to be undertaken periodically even if an indefinite award has been made, used as a means of policing the benefit. In some instances making shorter awards to start with this will enable a fuller picture to built up over time thus enabling a greater understanding of the extent of the diisability and how it impacts on the care/mobility needs of the person.</p> <p>13) Even when not undertaking a full review of the person's needs reminders can be include as they presently are in the letters issued yearly for uprating. A reminder could be issued in between either directly by letter or by using the available media costs and spending restrictions permitting.</p> <p>14) It would be helpful for the claim form to include a notes leaflet, the internet sites which are in the public domain need to contain the relevant information. It would therefore be part of the claims process. Frontline staff providing information need to ensure correct information is provided i.e leaflets and/or the spoken word.</p> <p>15) The Department already works alongside Welfare Rights and Disability Groups and Medical Professionals, it utilises the Internet and the Media. People do not take action when they are made to feel that they are asking for something which is not rightly theirs to ask for. The only answer I can see to that is personal contact from and by people who have the appropriate people skills.</p> <p>16) I do not realy understand what you have in mind with this question as Social Service have usually provided assistance with aids and adaptations would such a payment not give rise to risk of double provision.</p>

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	<p>17) If we take into account support that is being met from other public funds such as special education needs this would need to be accommodated for in the legislation for the new benefit. For example if the child's disability is such that they receive extra supervision at school throughout the day and this is reflected in their special needs funding that special needs funding is not detrimental to the child. It is advantageous in that it shows continual supervision is demonstrated throughout the day. If it shows that that supervision is to avoid the risk of substantial danger to the claimant or others the middle rate care can be awarded, the child gets the benefit of a cash award. The cash for special needs benefits the school budget who use that cash to benefit the child. Do we still need to look at the disabled child's needs being substantially in excess of that of a healthy child of similar age or do we just look at the disability and the dysfunction caused by the disability.</p>
ONLINE479	<p>1) unfortunately prejudice and ignorance. I have three daughters, one who is significantly disabled or 'special needs' as society likes to refer to - i prefer specific needs as she is no more special than her sisters or peer group! Opportunity just does not exist with having to jump through hoops - why over complicate things if my daughter wanted to go to the Brownies ( as my other did which gave me natural 'respite') it meant lengthy applications for funding for support workers - turned down which gave her less opportunity. This is one small example I have always maintained she will have No More and No less than her sisters as defined by their place in society What hard work overcoming this has it become!! Stop over complicating it</p> <p>2) the mobility component should remain in situ. Especially for those young people who have to receive their education many miles from home in a residential establishment. Costs to adapt vehicles will have to be met by parents of even hard pressed local authorities. Its pretty appalling that young people with specific needs have to be educated far away from families as the provision required is not accessible locally and removal of this component will restrict children and young people having regular contact with their families and loved ones</p> <p>3) support costs to access basic social opportunity. Costs of transport to often extensive and regular hospital appointments and meetings. Clothing and footwear - dependent upon specific needs</p> <p>4) guidelines need to be clear and not discriminatory</p> <p>5) automatic entitlement especially for life limiting conditions. Less invasive paperwork and slicker application methodology</p>
ONLINE480	<p>1) Access to public buildings, shops, entertainment venues etc. Public transport is not always accessible. People's negative attitudes to disability &amp; failure to think outside of the box</p>
ONLINE481	<p>1) General lack of understanding of the peaks and troughs of severity of conditions generally referred to as 'good days' and 'bad days' (this may occur yearly, monthly, weekly or even multiple times through day) meaning some people will endure or suffer through severe limitation to their daily living capacity on one day, then be able to manage more the next, but sometimes this extra activity on the 'good day' may actually cause a ripple effect, taking away this capacity on the next day or more as they recover. Limitations on accessibility to employment still very much exist, and 'wheelchair' accessibility is still not up to par, spaces allocated for disabled people, are usually somewhat patronisingly used for prams, so mashing the assumed 'dependent' together. (That is if you can actually get a space, be it parking, public transport etc) - if there is only one space on a bus, for a wheelchair user, but this is taken up by prams/pushchairs, or another wheelchair user, that wheelchair user will be required to get another bus, the ripple effect from this will then include, punctuality issues in work, leading to disciplinaries, this will cause demotivation due to the helplessness of the situation, and will potentially lead to the eventual unemployment of the disabled person in question. The people who try to lead 'independent, full and active lives' face the most challenges, this goes unrecognised, and they face the most demoralisation.</p> <p>4) It will certainly make the benefit more balanced, as previously care was seen as a greater issue than mobility. (when the causality of the mobility problems was somewhat irrelevant when claiming) as suggested above this benefit NEEDS to use the claimants worst days (and perhaps frequency of these) in their condition as the benchmark for their claim. There is a danger of over-simplification of a claimants condition by limiting the benefit to two rates, and I would want to see what the qualifying criteria will be for each rate, as I am concerned that the leap between the two rates will be impassable for many</p>

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	<p>who will need the higher rate.</p> <p>5) The stress, uncertainty and time required currently to claim for DLA is unacceptable. Many who should have been eligible for the higher rates have been refused, then those lucky enough to have had support accessing advice, have had these decisions overturned at appeal, and the higher rates granted - This should NEVER be the case - the system should represent the people it's targeted through, not put them through nightmareish interrogations in order to be granted financial assistance they are in need of, eligible for, and entitled to. For DLA, the application itself is incredibly convoluted, by using the claimants condition in certain circumstances as the qualifying criteria will simplify the claim-process, however granted, many conditions are still misunderstood, and some are affected in very different ways by the same condition, and hence it is vital that this is taken into account. I believe initially claims should be based on condition and information on the conditions effects from specialist consultants in the field (there will need to be information on the claimants individual circumstances, but this should be as stated above benchmarked to the condition at it's worst for the claimant and the frequency of this occurring), then the needs and circumstances of the claimant be looked into in more detail at reviews for their claim to continue, in order to ensure that they receive the correct amount of benefit.</p> <p>6) Prioritisation is a complex issue, in that you risk giving some conditions more importance than others, or losing claimants with multiple condions in the system. (i.e. someone with a mobility issue from birth, developing further issues later in life, and recognising that having multiple low-level conditions may impact similarly or more so, as someone with one severe condition) Just because someone can do something, doesn't mean that they should be forced to if it will create a worsening of their condition for example, having the ability to both go shopping and put the shopping away, is one this, but if this creates a severe level of exhaustion, meaning they will later in the day be unable to cook for themselves, or wash themselves needs to be taken into account.</p> <p>7) By asking claimants, not just if they are able to conduct tasks, but how doing so affects them.</p>
ONLINE482	<p>1) Costing especially if it is an ongoing costing and not a one off. My deafness means that I will require a sign language interpreter and the problems start when I go and buy a TV or a car and would like to ask questions, who provide and pay for this.</p> <p>Lack of understanding of deaf issues still the norm, we still do not have full access in areas of tannoy, theatre, employment, and with reducing input from the social services, especially in equipments I am forking out much more than previously. By the way I am in a full time job too!</p> <p>1) Deaf people may struggle to answer the questions due to their lower levels of english  2) The fact we get money from it helps as sometimes it would be good that we get a fixed numbers of hours of provision from a sign language interpreter rather than money to ensure that money is spent in the appropriate way. But we need money to pay for equipments etc  3) Specialist equipment, personal helper, sign language interpreters, subtitles, extra time to read information as most deaf people are way behind in their reading levels despite 'advances' in education!</p> <p>It would be lovely not to have to fork out extra money but this is my life and my colleagues take more money after bills etc whereas I pay more for equipment and interpreters so end up less in my pockets</p> <p>4) You are not happy with 2 levels - care and mobility. So how will that differ - it appears to be the same to me  5) Some disability such deafness and blindness should be automatic as there is ongoing costs and barriers still exist despite 'advances'. Other disabilities such as amputations or severe MS should be reviewed periodically  6) Communication is a priority to express the needs and desire and this covers many areas in shopping, recreation, employment, social activities, journey/travelling, visits to GP, phone calls, basic living. other priority (on a lower level) would be personal care, cooking and travelling  7) Regular assessment and covert operation -I know this is not ideal but this will observe people in their normal daily living  8) Yes and ALL of them. Due to cuts in social services, there are less equipments</p>

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	<p>available with many outdated and long waiting list. One example is the flashing fire alarm at a much higher costs - how many deaf people actually got those at home?!</p> <p>Should take into account of those that already has them as if that fails, how will they be replaced?</p> <p>9) Shorter and concise  10) GP, social worker, psychologists, audiologist, OT  11) It will be much better as the person will see how 'disabled this person is', but this person should be aware and sympathetic to all of the barriers faced. A sign language interpreter should be made available for deaf client  12) If they had not applied for dla previously then it should be more often. Also depending what kind of disability it should be reviewed yearly, 3 yearly or every 7 years - such as stroke, back injury  13) Clearer phone number and other mode of contacts such as emails. Also allowing more 'whistle blowing'. On phone lines should be able to connect immediately not busy or try again later which is off putting  16) I use my DLA to fund these</p>
ONLINE483	<p>11) atos healthcare will already control this and i believe it will be the same as the present system not a expert in your condition but a so caled healthcare worker maybe a nurse at best a doctor useing a computer program of tick boxes people have different problems and need to be looked at as individuals not tick boxes my own experience with them as been awful and i am waiting for my appeal to be heard but have been told there are so many appeals waiting to be heard it could take months the stress is not fair this is no more than a goverment policy to reduce payments topeople who are already suffering long term illness ?) people with long term illness have it hard enough now to try and get by day to day this will only make thier lives worse it is only being done to save money it has nothing to do with helping us it is just attacking the most vunerable i cant go on any protest marches or rallys as my mobility to walk any distance is impaired but i wish i could you should be ashamed at what you are doing</p>
ONLINE484	<p>1) TRAVEL; If you do not have a suitable vehicle, especially if you are a wheelchair user and need an adapted car. If the mobility component is removed from children (19 and under) who are weekly boarders at school,(ie mon to fri)these children will not be able to access the Motabilty Scheme. This scheme allows families to lease an adapted car (that otherwise would cost about £17000 for a basic car)for their child. If a child who boards mon to fri does not have this vehicle they will not be able to:</p> <p>be collected from school when they are sick</p> <p>go out at the weekends or holidays</p> <p>Basically they will be a prisoner in their own homes which will be in breach of their humam rights.</p> <p>In addition to this the mobility component supports the child accessing the community, whether that be paying for additional support to go out or for the extra costs of trave.</p> <p>2) The amount of money you receive is already not adequate to meet the costs of bringing up a child with disabilities so the amount for people with long term, extreme medical conditions should increase not decrease.</p> <p>3) Travel - adapted cars are very expensive.</p> <p>Additional cost of employing someone to assist you when you are out and about. If your the disabled person needs personal care when you are out with them, there are very few toilets with adult/large child changing facilities and hoists (even in hospitals!). So it requires two people to lift the person onto the floor (with a blanket on the floor) to be changed. This is degrading and back breaking stuff!!</p> <p>Housing - finding suitably adapted housing is very difficult if not impossible. There are many families with disabled children living in high rise flats which are damp and in desperate need of repair. Adapting a house/flat is very expensive so the Disabled Facilities Grant needs to be increased and most certainly not reduced.</p>

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	<p>When a disabled child is born into a family, there are life changing decisions to be made. Often one parent (usually the mother) has to give up work to attend numerous appointments and care 24/7 for the child. When most families would have saved up for a maternity break of maybe a year, the 'disabled' family is now stuck in poverty as they have lost one breadwinner. This will impact on their mortgage so they could be made homeless and reliant on already stretched social housing. It will also affect the whole family in other ways: there will be no more holidays, siblings will have a limited social life as parent/s are too exhausted or busy looking after the child with disabilities etc</p> <p>4) If the criteria for each level is transparent and able to take into account all aspects of disability it could be a good change. The concern is that now, for example, most severely autistic children/adults find it well nigh impossible to access the higher rate mobility component which would have in turn provided access to a motability car. As a result you find severely autistic people not being able to leave their own homes as they are not able to use public transport as their impairments can not cope with such situations. So they just dont go out. Another breach of their human rights.</p> <p>5) I think some conditions should gain automatic entitlement to the benefit, but we are talking about people who can not survive without a carer 24/7. It is humilitating and upsetting to keep having to fill out forms when it is glaringly obvious to everyone that the person has critical care and mobility needs. One thorough report from a medical professional (and there are usually many involved in such peoples lives) is enough for a lifetime of benefit. If it is clear that the person is going to be disabled for the rest of their life, why put them through the torment of having to restate the impairments every few years?</p> <p>6) The new Equality Act should be good starting point.</p> <p>Everybody should be entitled to go out and be part of the general community. However this is facilitated is of lesser importance. If people are forced to stay at home because of lack of suitable transport or finances to go out with support they may as well be 'locked up'!</p> <p>Suitable Housing is also essential. The additional cost of keeping a house warm for disabled people should be factored into payments or additional fuel payments made as for elderly people.</p> <p>Many disabled people have specific dietary requirements which means they often need special food prepared for them.</p> <p>If you dont get given enough pads for incontinence you might be forced to buy more yourselves. They are expensive.</p> <p>If you are incontinent you may well use your washing machine more often than none disabled people, you may need to buy extra clothes because of this as well. Related to this is the extra costs of drying clothes and bedding if needed.</p> <p>?) As much information that could be shared is the best answer to this one, with obvious due regard to the persons privacy.</p> <p>Various attempts to operate a 'Key Worker' system in different sectors have been attempted but don't seemed to have worked for some reason. May be this needs to be looked at again.</p> <p>?) As stated before, if you class chidren who are weekly boarders at a residential school as those who are in care homes and take away their mobility component you will have a caused a massive impact on their quality of life. They are children at school during the week that need to be out and about at weekends and in the holidays just like other children.</p> <p>?) Children are dependents and therefore having a disabled child affects the whole family and even extended family. Behind every disabled child is a 'disabled family'. Whereas the adult with disabilities may have left home, the child with disabilities will often still be living some if not all the time at home. There is a massive affect on the quality of life of all in that household.</p> <p>Children also still have hope for improvement, their schooling is key and the support that families receive up until the child leaves school at 19 is of paramount importance. Families</p>

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	<p>may well have gone to tribunal to get their child into a suitable school so they do not need the added stress of fighting for benefits that should be their passport to an independent fulfilling life, like the one everyone else expects.</p> <p>There should be no attack on the benefits that children at residential school receive. They are at school and are not in care homes.</p> <p>Transition into adult services is a very confusing time for older children. There needs to be much more support and transparency on how to get the most suitable placement for your young adult with disabilities. You should also not assume that the young person will go home to their aging parents and spend the rest of their lives in front of the TV.</p> <p>?) I personally am very concerned at suggestions that children's entitlements, in particular the mobility component for children who are weekly boarders at school, is under threat. Our lives and that of our disabled son would be made unbearable if we could not use the mobility car scheme. The passport to this scheme is the higher rate mobility component and as I appreciate the name of such a benefit will change the sheer thought that you may be taking away this benefit from CHILDREN WHO ARE AT SCHOOL FROM MONDAY TO FRIDAY is outrageous. These children are boarders at these particular schools for the sole reason that the local authority could not meet their EDUCATIONAL NEEDS. These schools are not 'care homes' they are schools. Families will already have had to fight to get their child into such a school, a suitable school, and now face losing their independence. This can not happen it is not right. Our son will not be able to be picked up when he is sick, go out at weekends or go anywhere on holiday if he loses his adapted car and mobility allowance. I really hope you will listen to people like ourselves who are caring for such children all our lives, to the best of our abilities and support us and not make our lives harder!</p> <p>?) If disabled people had to apply for everything rather than one benefit leading to another, there would be the additional cost of facilitating more form filling as well as the emotional cost for the individual. That is to say it is upsetting to have to re state your impairments time and time again, it is a constant reminder of your situation. The current DLA form is a prime example of how not to do it. If you are going to make the system more efficient and 'humane' limit the times people have to say how 'disabled' and different they are!</p>
ONLINE485	<p>3) Extra heating costs because people with reduced immune systems often feel cold. Disabled people also have higher grocery costs and prescription charges</p> <p>5) I think that all applicants with chronic conditions which result in disability should be automatic. I am thinking here of people with Respiratory conditions, Multiple Sclerosis, Parkinsons disease, MND, etc. Also people who are terminally ill should automatically be entitled</p> <p>7) It is essential that Healthcare specialists involved with the disabled person have the highest input. It is no use having medical assessments done by people without the experience of the condition. Take MS. My husband's MS fluctuates on an hourly basis at times, and it is likely someone not involved would fail to appreciate the impact of fatigue. It is not being tired, it is having every ounce of energy sucked out of you and you have no choice but to lie down. Things like tremor and mobility change on a daily basis too.</p> <p>8) If you are talking about a benefit to help someone live independently, then you should not take aids or adaptations into account. Surely the yardstick to use is against an able bodied person's ability. Some of the aids and adaptations are not freely available and the majority of people do have to pay a cost depending on what it is.</p> <p>10) The people best placed are the healthcare professionals ie GP, Consultant and Specialist Nurses plus Occupational Therapists. I know most people with MS feel they are more able than they actually are.</p>
ONLINE486	<p>?) At the moment your systems don't appear to be integrated. PIP gives you the opportunity to review the integration and ensure that the information is disseminated to ALL other relevant departments.</p> <p>1) I am 60 years old and suffer from Limb Girdle Type 2A Muscular Dystrophy. I led a "normal" life up to my early twenties. Since then my muscles have steadily deteriorated and I have been using an electric wheelchair for the last 13 years. The following problems/barriers prevented me from leading an independent, full and active life:</p> <p>1. GPs have very little knowledge of neuromuscular conditions and are usually unable to 'signpost'. I now attend the NeuroMuscular Centre in Winsford, Cheshire, which is a charity, and is the only place in the UK which provides specialist physiotherapy and advice for people with Muscular Dystrophy. If I had known of its existence earlier I could have</p>

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	<p>coped better with my condition.</p> <p>2. A suitable electric wheelchair is an absolute necessity for people with neuromuscular conditions. The one that I have costs £18,000, but this enables me to still live independently. The local 'Wheelchair Services' have neither the knowledge nor the funds to provide suitable equipment. However, a 'National Wheelchair Services' could have the knowledge, and, more importantly, the financial power to drive costs down in a market that is fragmented, unregulated and very uncompetitive.</p> <p>3. A suitable wheelchair needs to be matched to a suitable vehicle in order to retain independence. I drive from my wheelchair, and my vehicle cost £35,000. Again, the market is fragmented, unregulated and uncompetitive.</p> <p>4. Suitable home adaptations have enabled me to still live independently. However, finding out what is available is very difficult, and is always expensive.</p> <p>5. Public transport is often inaccessible in an electric wheelchair. The train service is accessible so long as you plan in advance and there is a 'space' available. Therefore you can no longer be spontaneous with your life.</p> <p>6. Suitable holiday accommodation is difficult to find.</p> <p>Basically what I'm saying is that I need 'information, information, information', and a level playing field when it comes to choosing suitable equipment.</p> <p>?) Duplication, Duplication, Duplication!!! This is often the most frustrating part of dealing with government/council departments. One has to explain the situation so many times to so many people. This MUST be looked at as it is not only a waste of money, it can also lead to a delay in receiving your entitlement.</p> <p>2) I note under point 10 above that you say "Individuals who receive the benefit before reaching 65 may continue to receive Personal Independence Payment if their needs continue." I would prefer the word "may" to be replaced with "will", unless you are considering changing the amount once state pension kicks in. This would be grossly unfair.</p> <p>3) As a wheelchair user my main extra costs are as follows:</p> <ol style="list-style-type: none"> <li>1. Cost of a suitable wheelchair. Could be up to £18,000 and lasts for approximately 10 years.</li> <li>2. Maintenance of wheelchair in order to ensure reliability.</li> <li>3. Cost of a suitable vehicle. Could be up to £35,000 and lasts for approximately 10 years.</li> <li>4. Maintenance of the adaptations on the vehicle in order to ensure reliability.</li> <li>5. Additional insurance premiums on items 1 and 3 above.</li> <li>6. Adaptations around the house. My extension cost over £50,000, but it enables me to be independent. Wheelchair users need space and space costs money.</li> <li>7. Help to do daily chores around the house, e.g. cleaning, decorating, changing the bed, washing clothes, moving furniture around, hanging pictures, gardening, putting rubbish out, shopping, etc, etc.</li> <li>8. Ongoing maintenance around the home - you always have to get someone in as you can't do it yourself.</li> <li>9. Suitable accommodation on holidays is always more expensive than the 'last minute' bargains that able bodied people can get.</li> <li>10. You almost always have to use your own transport as public transport is not universally accessible. Thus you cannot take advantage of the many travel bargains that are on offer.</li> <li>11. Specialist equipment is always more expensive than its able bodied equivalent. E.g. rise/recline armchairs, baths, profiling beds, etc.</li> <li>12. 24 hour emergency cover via neck or wrist pendant.</li> </ol> <p>4) The administrative saving of reducing the levels from three to two will be absolutely minimal. Keep three levels, and if possible increase it to four. Having an even number of options ensures you don't always go for the safe choice of the middle option. Having just two levels reduces the flexibility and the latitude that can be exercised. This seems to me to be an excuse to save money by excluding certain 'lower levels' of disability.</p> <p>Question? Under this proposal would the current budget be split over the two levels or would the current budget be reduced?</p> <p>5) I am in favour of individual assessments. However the assessment needs to be carried out by the 'right' people.</p> <p>In my case I know far more than my GP about Limb Girdle 2A Muscular Dystrophy (MD) and the effect it has on my day to day living. Also, because MD is a progressive condition</p>

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	<p>two individuals with the same condition will not have the same degree of impairment. Similarly my consultant is an expert in my medical condition, but does not understand how it affects my daily life.</p> <p>For my condition I would seek input from the NeuroMuscular Centre in Winsford, Cheshire where I attend for regular physiotherapy. They are the only people I would trust to make an objective assessment of my condition and how it affects my day to day living.</p> <p>However re-assessments may not be necessary in all circumstances. In my case Muscular Dystrophy is progressive so you are always going to deteriorate and so once you are on the top level of DLA and there is no chance of any improvement then re-assessments are not necessary.</p> <p>6) My approach is to break it down into time categories, and identify what tasks you can/can't do without help. (N.B. 'Help' can mean assistance from objects as well as people. E.g. a wall can assist someone to walk without falling, a table can assist someone to stand up.):</p> <p>DAILY</p> <ul style="list-style-type: none"> <li>Getting out of bed</li> <li>Getting on/off the lavatory</li> <li>Standing up</li> <li>Sitting down</li> <li>Going up steps</li> <li>Going down steps</li> <li>Walking</li> <li>Getting washed</li> <li>Getting dried</li> <li>Getting dressed</li> <li>Combing hair</li> <li>Putting glasses on</li> <li>Opening doors</li> <li>Transferring to the kitchen</li> <li>Getting children up</li> <li>Lifting children</li> <li>Dressing children</li> <li>Helping children</li> <li>Adjusting Central Heating</li> <li>Answering telephone</li> <li>Opening cupboards</li> <li>Opening packets</li> <li>Picking objects up off the floor</li> <li>Making breakfast</li> <li>Communicating ones needs</li> <li>Understanding responses</li> <li>Using cutlery</li> <li>Lifting heavy objects</li> <li>Making cups of tea</li> <li>Putting coat on</li> <li>Putting hat on</li> <li>Transferring to vehicle/public transport</li> <li>Getting to work</li> <li>Parking at work</li> <li>Using umbrella</li> <li>Transferring to office</li> <li>Getting drinks during day</li> <li>Going to meetings</li> <li>Getting lunch</li> <li>Going to lavatory during day</li> <li>Getting home</li> <li>Making evening meal</li> <li>Socialising</li> <li>Switching on electrical apparatus e.g. TV, music,</li> <li>Changing channels</li> <li>Drawing curtains</li> </ul>

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	<p>Washing up            Getting undressed            Getting into bed            Getting out of bed during night</p> <p>Assistance whilst asleep (e.g. breathing aid, catheters)            WEEKLY            Washing clothes            Hanging up washing            Ironing            Shopping            Putting shopping away            Cleaning            Socialising, e.g. going out of the house            Entertaining, e.g. friends coming round to your house            Gardening            Changing bedding            MONTHLY            Maintenance around the house            Work trip away from the office            Working late at work            Getting a haircut            QUARTERLY            Having friends to stay            Going on a weekend away            SIX MONTHLY            Going on holiday            I'm sure there are many, many more!!</p> <p>7) Is DLA (or PIP) the right vehicle to address these conditions? Should there be a time limit? E.g. if the condition is likely to improve within 12 months then PIP is not appropriate.</p> <p>8) For me the following items are vital:</p> <ol style="list-style-type: none"> <li>1. Electric wheelchair</li> <li>2. Clos-o-Mat toilet which washes and dries without help from any other person.</li> <li>3. Toilet riser which enables me to get on/off toilet without help from any other person.</li> <li>4. Rise/recline armchair</li> <li>5. Profiling bed</li> <li>6. Wet room shower/bathroom</li> <li>7. Adapted kitchen</li> <li>8. Ramped access to house</li> <li>9. Suitable vehicle</li> </ol> <p>The assessment must consider aids/adaptations that the person might be eligible for. What people already have is a function of income and not need.</p> <p>9) 1. There must be an electronic version which allows lengthy responses. Vital information may be missed when one is restricted to a 10cm x 10cm box on a paper form. Editing responses also becomes easier. In fact electronic format should be mandatory as this would enable the information to be accessible, retrievable, and able to be analysed.</p> <p>2. Support must be available from independent third parties to provide assistance with completing the form. (They could also provide the electronic link for those individuals who are not used to the electronic format). The NeuroMuscular Centre in Winsford, Cheshire already helps their clients to complete the current DLA form.</p> <p>3. The process must explain the terminology in simple terms. E.g. 'help' to most people usually means assistance from a person. But 'help' can come from things as well, e.g. a wall can provide support when walking, a table can assist someone to stand up, a bed on bricks assists someone to get out of bed, an electric wheelchair assists someone to get around independently, etc, etc.</p> <p>10) As I have already indicated, my GP, OT and consultant are not best placed to provide this information. My GP and consultant may understand my condition but without spending a substantial amount of time with me they have no idea of how I cope with my condition on a day to day basis. The best source of information for my condition (Limb Girdle type 2A Muscular Dystrophy) is the NeuroMuscular Centre in Winsford, Cheshire. I attend the centre every two weeks for physiotherapy which is not available on the NHS. It also</p>

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	<p>provides practical support and advice for coping with the day to day problems that occur when one is diagnosed with Muscular Dystrophy.</p> <p>11) If its the 'right' person conducting the face to face process and there is sufficient time allocated then there is no problem. The danger is that it will be the 'wrong' person and it will be a time limited exercise.</p> <p>Healthcare professionals by their nature deal with health issues. It is rare that they understand how the health problem affects the individuals day to day living, and this is what DLA (or PIP) is trying to enhance.</p> <p>A further issue is that some individuals are reluctant to admit their problems, and the healthcare professional must 'tease' the information out in order to ensure that the individual gets the correct level of PIP.</p> <p>12) Some conditions (such as mine) only get worse. Therefore there seems to be a case for allocating conditions into certain categories. The DHSS must have a vast database of information about current recipients and this should be the starting point. For instance my DLA is already categorised as 'for life'. This doesn't mean that I shouldn't be reviewed but the frequency should be, say, every 5 years rather than every 12 months for different conditions.</p> <p>If my condition does deteriorate and I am not on the maximum PIP then I should be able to instigate a review.</p> <p>Question? What should be the minimum review period?</p> <p>13) Basically you can't!! Inertia is a part of human nature. This ties up with the previous question and the impetus has to come from the DHSS. If you get the conditions in the right time categories and each of these has a certain review period, then you have to bite the bullet and initiate a follow up review. If you get it near enough correct then the cost of extra reviews should be less than the overpayments of PIP.</p> <p>14) It breaks down into two basic areas:</p> <ol style="list-style-type: none"> <li>1. Equipment</li> <li>2. Services</li> </ol> <p>Within Equipment there needs to be a NATIONAL directory of what is available and the suppliers. This must include PRICES as we need to encourage competition and bring down prices to a more reasonable level.</p> <p>Within Services it probably has to be done at a LOCAL level, but this needs to have NATIONAL guidelines. For instance I am not eligible for any additional financial help from my local council as I have some savings. However I still need to know what services are available and where I can get them. I would like to see some online directories where one can browse the services available in your local area.</p> <p>A directory of conditions and those organisations that support those conditions should be available online. E.g. For Muscular Dystrophy the Muscular Dystrophy Campaign (MDC) should be signposted as should the NeuroMuscular Centre in Winsford, Cheshire.</p> <p>15) It is difficult to 'require' someone to access advice and support as there are many reasons why the individual has chosen not to. E.g. the individual may be in denial about their condition, or their partner may be having trouble in coming to terms with the situation. What could work is a 'Listening Service' where individuals and their families can discuss the situation but with no requirement to take it further.</p> <p>16) If one has savings then one does not qualify for any help with paying for adaptations. Therefore they have to pay for them out of their own pocket. Aids and adaptations are ALWAYS expensive. e.g. a profiling bed (which doesn't look like a hospital bed) can cost over £2000, a rise/recline armchair costs £1500. Compare these with the prices you see daily on the TV.</p> <p>There is a real need to bring in competition to drive down prices and this can be achieved by having National Directories where all the options are published with prices.</p> <p>if you do qualify for support from your local council, then the decision is often made on cost rather than what is the most suitable. This mismatch may be alleviated by having National Directories with published prices and introducing competition.</p> <p>It is difficult to see how PIP could be used to meet a one-off cost, and, more importantly, it is not what PIP is designed to be. As I see it PIP is to help an individual with DAY TO DAY costs, not one-off needs. Additional funding or different solutions MUST be looked at.</p> <p>One solution could be to extend the current 'long term loan' facilities that exist for certain items. E.g. my Clos-o-Mat toilet is on 'long term loan' from my local council and is maintained by them.</p> <p>Another possibility is to use a small proportion of PIP to 'hire' a piece of equipment on a</p>

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	<p>long term basis. This would be similar to the Motability scheme. From what I have read Motability can negotiate large discounts due to their bulk buying power. Could something similar be introduced for aids and adaptations??</p> <p>?) Ensuring that the 'right' people are consulted during the assessment is vital. For my condition (Limb Girdle Type 2A Muscular Dystrophy) the right people to consult would be the NeuroMuscular Centre in Winsford Cheshire.</p> <p>My GP will not see many cases of Muscular Dystrophy (MD), and is unlikely to understand how it could affect my day to day life.</p> <p>My consultant will understand my medical condition, but, again, has little understanding of how I cope on a day to day basis.</p>
ONLINE487	<p>1) The removal of 25% of disabled people's DLA will prevent many from leading independent, full and active lives and isolate many from today's 'big society'.</p> <p>2) People living in care homes should retain their mobility DLA. Removing their only means of access to transportation is cruel and unnecessary.</p>
ONLINE488	<p>9) Make questions closed so not as to catch people out but be able to extract the basic information required to make a decision.</p> <p>make the benefit available to all who fit the criteria dependant on need and problems that occur, support ,not only help with care and getting about , but general living problems taht are encountered ,</p> <p>give examples, have staff available to advise and give feedback , or to question. not just a form filling exercise on line .</p>
ONLINE489	<p>1) The attitudes of non-disabled people, who seem to think that if you are out on your own, and claiming DLA, you are committing fraud.</p> <p>3) visual aids, and addition of hand rails to the home.</p> <p>5) It should be needs and circumstances dependent.</p> <p>5) Yes, having 10/60 or less of vision.</p> <p>7) For my visual problems, assess over a period of 2-3 days.</p> <p>8) No, because the adaptations are funded by a mixture of my own money and DLA</p> <p>8) NO, because the aids need to be funded somehow, and I for one use my DLA to fund aids.</p> <p>13) When an application is successful, send a non-exhaustive list to the claimant, in their preferred format, of what sort of changes should be reported depending upon their individual situation.</p> <p>16) With a mixture of DLA and my own funds</p>
ONLINE490	<p>1) physical limitations, chronic pain, and the fear of not being comfortable when you go out stops some people, like myself, from wanting to do things. sitting in an upright chair in a restaurant , for instance, is painful. most seating in theatres, cinemas etc has very limited legroom, and therefore a person can feel,although unintentionally, ostracised.</p> <p>2) i think DLA has been far too easy to abuse . as it is subjective, and therefore not specific to any medical condition, it is not properly scrutinised, and often given to those who really do not need it. i believe it is about time that it was reviewed.</p> <p>3) i have a motability car. without it i would not get out very much . i could not stand and wait for buses, trains etc, as standing causes pain. so, extra costs are for things like using taxis if you dont have a car, extra petrol for shorter journeys which most people would walk if you do have a car. Extra heating in the winter for many disabled people. having someone to help you at home to do the normal everyday things that most people take for granted. not everyone has family to help them, so outside help is often necessary.</p> <p>PRESCRIPTIONS!!! there are savings to be made with a yearly paid prescription but that is still expensive.</p> <p>4) you must have two components otherwise people who fall into only one category will not be eligible to claim.</p> <p>5) No benefit should not be automatic.many people have conditions which, on paper may sound terrible, but which does not affect them at that moment in time.</p> <p>it should be based on the individual and their current state of health with regular reviews unless the condition is degenerative</p> <p>6) being able to maintain independence. being able to do normal things like going</p>

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	<p>shopping, accessing education.</p> <p>The ability to look after your family is often overlooked. As a mum with a disability i miss not being able to be out and about and active.</p> <p>8) If a person is a wheelchair user, then they are already disadvantaged, and obviously the wheelchair, although it does give them the ability to be mobile, it does not take away the disability, or the pain, or the other effects that living with disability causes.</p> <p>i have a perching stool in my kitchen which enables me to do more, but if you took that into account and refused benefit because i can then technically stand for more than 5 minutes , then you are not recognising that the only way i can carry out an everyday task is with the help of that aid, and therefore it should be ignored.</p> <p>I use a mobility scooter which i use when i go out with my family. it doesnt mean that with it i am able bodied, does it? therefore it should not be taken into consideration.</p> <p>The same applies to crutches, sticks etc.</p> <p>If a person doesnt use any aids for walking and you should consider that person as though they could obtain them, then that basically means that they didnt need them in the first place, and should not be eligible for a disability benefit.</p> <p>9) i think it should be applied for in a face to face interview, which although is more costly than a paper form, would stop many people who are not entitled from claiming, who would make a claim with the current format.</p> <p>however, unlike the current medicals, carried out by ATOS for the ESA , it should be dignified and carried out without the assessor being paid for each individual . We know that most ESA claims are turned down and have to go to appeal due to the dreadful ATOS assessment.</p> <p>There needs to be radical change.</p> <p>medical records should be seen, and evidence that the condition is being treated by a consultant at a hospital rather than by a gp. That shows that the individual has been diagnosed properly and is under the appropriate care, and not having just been to the gp who deals with only everyday illnesses,. if you have not been referred to hospital and undergo current treatment, then you are unlikely to need such benefit.</p> <p>referring to the person i spoke of earlier regarding having the DLA higher rate mobility, i must mention that he has not been referred to the hospital , but has only had an x ray showing early onset arthritis. Therefore, if no treatment is offered, ie, steroid injections, replacement etc, then the condition,although on his medical records, is of no significance at this time, as it does not warrant hospital consultation.,therefore not serious enough to meet criteria for dla. The Dla higher rate mobility is for 'those who are virtually unable to walk or who have no legs below the knee'. i would say that quite categorically that anyone in that category would be under the care of a hospital, or would have been for a period of time, and then referred back to gp care for ongoing treatment as stated by the hospital. This also backs up the idea that it would then be clear to anyone who may wish to apply for DLA of the criteria for DLA and why a disabled person applies for it. Heart and pulmonary diseases which cause severe breathlessness also impedes a persons ability to walk without discomfort, and those affected to that degree would also normally be, or have been, under the care of a specialist.</p> <p>I believe that you should make it clear that the benefit is for those who are truly affected in their day to day life by their illness or disability.</p> <p>10) see my response above!!</p> <p>Hospital consultant.</p> <p>Hospital records showing how a condition has progressed etc.</p> <p>11) it should have been this way all along. no person who has a genuine claim has</p>

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	<p>anything to fear because if they meet the criteria they will get the benefit. however, the difficulties that may arise could be from those who are currently on the benefit who are clearly not entitled as they have never had a medical in many cases .</p> <p>Unfortunately, we all of us sometimes have to face interviews, be it a job interview or similar even though we may not like the idea. however, there is no question that had there been a face to face consultation with the current DLA then the massive increase in claimants may have been avoided.</p> <p>If a person doesnt wish to be interviewd in any circumstance, then one has to question the validity of the claim.</p> <p>12) I can only comment on my own disability regarding ongoing evidence, and that would be by mri scan reports which show that my condition is degenerative, and which will increase my level of disability over the coming years.</p> <p>Letters from the hospital giving information about the claimants ongoing condition should be easy to obtain. X-rays are of little value, with scans showing much more in depth detail of degenerative changes, or improvement in the claimants condition.</p> <p>If a person is on a waiting list for surgery for certain types of major surgery they should be eligible, ie, transplant surgery, by-pass surgery, joint replacement etc. ~once surgery has taken place , and a period of time for rehabilitation, another review should be set.</p> <p>As many people have conditions which can be stabalised with use of replacement joints, there should be reviews when this has been done, although with multi joint arthritis, as in my case, as in many others, it is more complex.</p> <p>13) Firstly, if the benefit were not so easy to get then there would not be so much fraud.</p> <p>It is my opinion that some people do not tell you of a change in circumstance, ie, an improvement in their condition, because they were the same as at the beginning of the claim.</p> <p>As with all benefits , there is an element of trust on the part of the DWP when expecting people to inform you of an improvement or change in circumstance which could ultimately lead to a reduction in benefit. unfortunately we are in 'benefit for life' culture.</p> <p>if the new benefit is to include regular reviews, then that will help to manage some changes in circumstance. The claimant would also be aware of any review that may be coming up, and would be more likely to inform DWP of any improvement in the knowledge that any forthcoming review would possibly bring it to light anyway.</p> <p>Currently,as far as DLA is concerned, the lack of contact with the claimant once the benefit has been awarded is, in itself,the cause of such activity.</p>
ONLINE491	<p>1) For someone with little or no sight, communication and mobility are two of the biggest problems. other problems are many and varied but include security, confidence, ability to have their voice heard (it took me nearly 2 hours to work out how to use this consultation process for example and only then because someone set it up for me!) adaptations from others (for example employers).</p> <p>2) The level of distress being caused by the potential reorganisation is extreme. Whatever changes are now made should be done with this in mind as we are witnessing large scale worry.</p> <p>The split between personal care and mobility should remain as these are two very dfferent elements of sightloss disability.</p> <p>A simplification of the system would, however, be good as it is badly understood by a lot of people.</p> <p>3) Expenses include the need to get someone to do a lot of things you would otherwise do yourself (someone with no sight needs a helper to trim hedges, clean, garden, choose clothes, mend things, read things, check bank statements etc). Also the fact that everything tends to take longer - eg transport can't just 'pop to the shops' in a car, need to</p>

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	<p>wait for a bus, go the route the bus goes, walk back to wherever you wanted to go rather than direct door to door. Security costs eg making sure you're safe as you can't see who's at the door/ringing you. Using things that others take for granted - eg computers have good access software but its expensive, adaptations tend to be expensive. Additional cost of wastage (eg food, never sure whether its still in date/mouldy so err on side of caution), buy a lot of ready meals as less difficult to prepare.</p>
ONLINE492	<p>18) Are there things we can do to improve these passporting arrangements?</p> <p>-The services and entitlements help me to meet the additional costs of having a disability, without such entitlements I would not, for example, be able to attend appointments</p> <p>To improve such passporting arrangements, links could be vastly improved between the various services to enable disabled people to be more aware.</p> <p>1) DLA is not a barrier to preventing Disabled people participating in society! in fact it enables deaf people to meet other like minded deaf people and start Deaf Clubs, Deaf Societies and Deaf Businesses. It is empowering not giving us self esteem problems. I am sorry but I completely disagree. Removing this will isolate deaf people and create self esteem problems. social problems. social networking is no substitute for face to face contact. This is known to counter depression and deaf people travel the length of the country to meet other deaf that they can communicate on their level(BSL, lipreading, speech etc)</p> <p>The main barrier is DDA laws preventing deaf people gaining meaningful employment. Since the removal of the green card 5% rule of the workforce being disabled employers have no obligation to recruit disabled people. this is causing deaf people to become 2nd class citizens and outside the main loop.</p> <p>I am sorry but there is no way you can reform DLA/PIP without addressing the real problems of employment that deaf/disabled people currently face.</p> <p>Also when in employment deaf people face problems such as the glass ceiling and the DLA is a good barrier against self esteem problems developing. It gives us the determination to overcome and identify equipment or training that may solve these barriers.DLA does not preclude disabled people entering employment so thats where your argument fails. Disabled people are more likely to qualify for DLA and face significant employment hurdles particularly in the recession and in the light of recent shortsighted legal changes.Your link between DLA and employment is tenuous.</p> <p>If the government is determined to reform DLA then you have to have a meaningful programme to get disabled people with ability back to employment. Otherwise your words are empty. You have to back it up with serious action and positive discrimination that continues AFTER the disabled person gains employment.</p> <p>Ignorance &amp; prejudice is at an all time high and these contribute to the marginalisation of deaf people. I ask you why in this era of texting and twitter , social networking Access for deaf people is poorer than ever due to lack of technological progress?? For instance web videos are rarely subtitled with the exception of iPlayer! 4OD is a mixed bag but the rest of the web is poor.</p> <p>Disabled and deaf people suffer because "experts" know better and our views are never taken into account which I feel is the likely outcome of this consultation. Merely reforming DLA to PIP is only the tip of the iceberg of a social problem too many of you are happy to sweep under the carpet. Well its time some of you took responsibility and identified the root problems</p> <p>1) If PIP was used to replace DLA this would have a negative and adverse impact on the confidence of disabled people who are under various pressures socially, financially, emotionally, professionally.</p> <p>It is a poor time to reform and cause upheaval. Also you are reforming the wrong area. Why not tackle the problem top down?</p> <p>Change employers attitudes towards the disabled. At the moment there is a convenient "out of sight out of mind" model but you are heading towards the european model of impoverishing disabled people.</p> <p>Why not introduce legal reform to change those unfair employemnet laws and postive discrimination to socially advance disabled groups and when sufficient progress has been made reform disability benefits at a time when the impact will be less.</p> <p>To summarise the root causes are societal prejudice &amp; discrimination that foster low self-esteem. not DLA in itself. Until those are properly address any reform should be</p>

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	<p>sensitive or even delayed</p> <p>2) Disabled people would no longer be independent and have freedom of choice. Instead we will get decisions foisted upon us. We would then use unqualified and cheap interpreters. A reduction in our social mobility and independence if we no longer had access to Blue Badge Scheme and the Bus Pass. I say bus pass as DLA is used as a criteria for qualification. If our PIP becomes irregular and infrequent it becomes less worthy as a means of identifying disabled people. It no longer becomes a benchmark and would throw a lot of services into chaos if it was not possible to use PIP as a passport to other benefits and services</p> <p>2) People who have been classified as disabled for life should not be reassessed this is waste of resources and logistically burdensome. Deaf or Blind people are likely to remain so for the rest of their life for example. I do not view solutions such as Cochlear implants as solving the problem. This helps people to meet halfway but they should still be identified as disabled as they will suffer discrimination and marginalisation as they are not the "norm" More transient conditions such as Dyslexia, RSI, back problems, minor ailments should be monitored as people can continue claiming after their problems disappear. This causes a burden and is unfair on genuine claimants who use the money as a leveller in their lives</p> <p>3) Disabled people get more costs as have to travel further or buy more expensive equipment that have not been lowered due to supply and demand. We have to cover the costs of an interpreter/communication support in our leisure time. We stay longer on the phone as telephony advances have been ZERO in the last 20 years. Car insurance costs are higher Because we are Deaf despite that deaf people usually have above average eyesights and dont have the usual distractions like music and mobiles. This is because we cannot get our point across. Ignorant people (i include experts and professionals here) always think they know better. This impacts our esteem. If you remove mobility component then I hope you are going to leave transport passes for buses? This increases social mobility for disabled people and in turn travel further to jobs / social gatherings which addresses those self-esteem problems. One or the other has to be removed but not both which would mean that its just a cost cutting exercise. Currently deaf people pay for trains and DLA mobility helps to budget for the Travel pass for 1/3 off and to bring along a carer. Deaf people are likely to be more economically disadvantaged and this brings self esteem in their lives and confidence being able to travel. why not extend the travel pass to trains so we can get on "our bikes" and look for jobs? I would accept the removal of mobility component if we had a national travel pass but remove both then its exposed as purely cuts. Despite modern technology Access is at an all time low and you need to improve this for disabled people particularly those with invisible disabilities such as deafness we often have to travel to another town just to watch a film subtitled and sometimes they dont come on and our money is wasted. Extra costs include staying longer on the phone as there has been ZERO advances in telephony for deaf people in the last 20 years. We pay more for our car insurance because we are deaf despite deaf people having above average eyesight and are not subject to the usual distractions of music and mobile phones. This is due to ignorance from experts</p> <p>3) In my experience joined up thinking in councils almost invariably lead to failure so best have one criteria for qualification ie DLA and it is down to the disabled person to divulge information or give consent to information being shared</p> <p>4) If you have two rates I would suggest that you leave the permanent disabilities such as deafness blindness cerebral palsy etc on the upper rate to reduce logistics. The lower rate should be transient disabilities to be checked upon. if genuine disabled people are moved to lower rate then I would raise the need for new employment laws that encourage employers to recruit disabled people with ability. Otherwise how are we going to meet the financial gap? even within employment positive discrimination needs to take place. I have noticed a marked decline in the visibility of the two ticks symbols . Why? for mobility I think its unfair on those with severe mobility needs to be reduced .as they pay more on petrol carers etc in this age of rising fuel this is a regressive change. As a deaf person i am happy to have lower mobility requirements or accept the loss if a national travel scheme was implemented. The reason for this is that bus drivers find us</p>

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	<p>very difficult to communicate. if we are quiet i feel this helps us blend in the background and feel like a normal member of society. where we can read or keep ourselves to ourselves to contemplate our plans for the day</p> <p>If you have two rates I would suggest that you leave the permanent disabilities such as deafness blindness cerebral palsy etc on the upper rate to reduce logistics. The lower rate should be transient disabilities to be checked upon.</p> <p>if genuine disabled people are moved to lower rate then I would raise the need for new employment laws that encourage employers to recruit disabled people with ability. Otherwise how are we going to meet the financial gap? even within employment positive discrimination needs to take place. I have noticed a marked decline in the visibility of the two ticks symbols . Why?</p> <p>for mobility I think its unfair on those with severe mobility needs to be reduced .as they pay more on petrol carers etc in this age of rising fuel this is a regressive change.</p> <p>As a deaf person i am happy to have lower mobility requirements or accept the loss if a national travel scheme was implemented. The reason for this is that bus drivers find us very difficult to communicate. if we are quiet i feel this helps us blend in the background and feel like a normal member of society. where we can read or keep ourselves to ourselves to contemplate our plans for the day</p> <p>5) Those with permanent and intransigent disabilities should be automatic.It should remain non means tested as I find it irrelevant how much income a disabled person receives. The extra costs associated with the disability will remain the same</p> <p>Transient disabilities such as back pain,RSI should be based on the needs and circumstances of the person and obviously their condition can improve</p> <p>6) As I have said before a National Travel pass to enable disabled people to travel the length and breadth of the country on bus , train, tram would be essential for the quality of life for disabled people. That way we can travel further to jobs and broaden the range if travel passes are encouraged.similarly legislation to encourage employers to recruit disabled people, at the moment there is NO obligation to employ disabled people so this issue is skirted around.</p> <p>A subsidy to travel companies could take the stress out of evaluating individual PIP needs which sounds like a logistical nightmare not to mention taking time to process. You have to improve social mobility for disabled people in order for this reform to be successful.</p> <p>7) As I have said before distinguish between permanent and transient conditions and this will improve the administration and reduce unnecessary costs.</p> <p>Also someone with dyslexia doesnt need transport help but someone with back problem does.</p> <p>Severe disabilities it becomes a social need to travel and meet like minded people as our conditions are socially isolating and to deprive them of this would probably increase mental health costs in future- ranging from depression onwards</p> <p>8) Due to social work cuts there is a bigger burden on us to identify expensive replacements so it is the wrong time to cut,</p> <p>I do not think you should assess what aids and adaptations as everybodys needs vary. some need interpreters others lipspeakers, some amplifying aids,</p> <p>If this is going to be called Personal Independence Plan dont you think the final arbiter of the decision should rest on the individual? otherwise you are effectively removing freedom of choice</p> <p>9) If you want to make the claim form accessible to deaf people then why dont you have a BSL version online but it may be difficult for the deaf person to respond.</p> <p>You have to communicate effectively through agencies and disability organisations. But in the past you have consistently failed to do so. Take typetalk for example nobody is aware of this .Hearing people do not use text direct.</p> <p>Reason BT didnt advertise this service effectively. You should not make the same mistake. Delinate the disabilities clearly. Say if you are deaf, blind, wheelchair user you are able to claim this benefit,</p> <p>Other disabilities are too open to fraud,</p> <p>You can hardly pretend to be deaf, blind or paraplegic</p> <p>10) GP medical record to state the disability.</p> <p>For successful reform those permanent disabilities have to be identified clearly.</p> <p>Paraplegic yes. walking sticks crutches grey area</p> <p>Profoundly deaf yes hard of hearing perhaps not (decibels loss - use telephone as a cut off</p>

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	<p>point)  Blind yes short sighted (perhaps ability to drive etc as a cut of point)  For successful reform clear identification is necessary otherwise too many people will get on the bandwagon,  DLA should not be for people with RSI or "back problems"  11) How can deaf people talk to healthcare professionals directly without the assistance of an interpreter.  It is hard enough dealing with my GP so someone unfamiliar is very stressful.  It is inappropriate to question someones severe disability particularly when you have all the information on record.  Target those with grey areas.  12) If the nature of their disability doesnt change over time then they should be on a higher rate as its unlikely circumstances will change.  For more transient disabilities review them more frequently i.e annually so that the claimants who persist are genuine.  Most importantly change the infrastructure of society so that it deals with disabilities better  13) more frequent GP check ups to reduce potential fraud for transient disabilities.  More effective communication to increase awareness of reporting a change in circumstances  14) I would delineate the disabilities and link them to disability charities who can advocate and help support the disabled person.  If a person does not get higher mobility then he can use a bus pass for park and ride etc  Otherwise remain as blue parking scheme for those severely disabled. The Bulk of DLA goes towards maintaining the car so fuel costs have to be covered independently. This is further evidence that perhaps people who claim DLA usually work.  A lot of aids should be developed for disabled people but because there isnt a market one off payments are very expensive.  The higher rate DLA only covers a DAYs worth of signing so we have to meet the costs elsewhere  15) There needs to be effective commnication at a local grass roots level- to local charities social workers etc.  There has to be partnership and monitoring of those most in need as they may be the last people to claim  16) This is a difficult question as disabled people are now increasingly paying for their own services and equipments and this is why changes have to be sensitive as it is a very bad time to reform at at time when there is no national recognised program to get disabled people back to work  I dont agree with one off charges which will be an extra burden as we are already starting to pay more for services and equipmenty. It will impact our budgeting for the year.  17) Children cannot decide for themselves  The adult continually assesses the childs needs.  For example frequent holidays may enable a child to become more sociable and fit in society than if they were cut off completely.  There is no one size fits all with children they are all individuals and should be assessed on their merits. This is where an expert may make an incorrect decision. Children change as they grow older.  To simplify permanently disabled children will always remain so I am wary with the expert position that correct aids and adaptations one ceases to be disabled .I disagree vehemently and you could argue that people with cochlear implants become more disabled with additional emotional needs and speech impediments associated with the implantation.</p>
ONLINE493	<p>2) no. each individual should be assessed in person. it would be very easy for me, when completing the form for my daughter, to over-emphasise any problems - ie when the household has closed down for the day. i could say that i have to get up every 2 hours to see to her needs, and who would be able to refute that.  3) travel cost5) yes, some conditions which are permanent should mean automatic entitlement - ie cerebral palsy. the money wasted on filling out forms every two years on a permanent condition is stupid  s - we must use a car in order to get around. clothing -</p>

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ONLINE494	<p>1) Whilst I can see that a social model of disability is helpful, it is not the full story. If society was perfect and equalising in all regards to disability, I would still have a huge problem and be restricted in how much I can be a part of society because I am ill.</p> <p>My pain, my mental health issues, my awful thoughts/flashbacks/nightmares, my immobility ... none of those things will go away. No matter how much the government changes society to make way for difference caused by disability, I will be limited by my physical and mental health problems because I will still need time in hospital, time at doctors appointments and help to function no matter what.</p> <p>The things that are barriers are public opinion, media coverage, bad access to public spaces/transport/shops etc, being less well-off because I cannot earn any money, not being able to keep up with friends and go to parties/pubs because I am too scared ...</p> <p>It is the money and other peoples attitudes towards my problems that cause the most difficulties.</p> <p>However, even if those things were fixed, I would still struggle due to the symptoms I have.</p> <p>No reorgansiation or legislation can take them away.</p> <p>2) All of it. The personal independence payment is not clearer, more accessible, or an easier system.</p> <p>Leave it alone! The government is changing so many things, so many benefits and so many social care/healthcare aspects of daily life - why must my income be under question as well at the same time.</p> <p>The assessments however, should change. I believe that ATOS or any other agency cannot fully assess my conditions just by a one-off interview and answers to a fixed questionnaire done by a stranger how may or may not be qualified in the areas of difficulty I have.</p> <p>My GP and care co-ordinator are far better placed to assess my conditions. They know me, they have seen me over a period of time and surely they arem better qualified to decide whether I can work or not?</p> <p>I would also keep the fact that DLA is a passport to other entitlements such as higher premiums for income support, blue badges, other disability support.</p> <p>Finally, the motorbility aspect must remain also. The ability to have a car rather than just the money is a vtial aspect of freedom that many people rely upon.</p> <p>3) I can only answer for myself. I need higher heating to help my condition during the winter months as getting cold exacerbates my illness. I then need more electricity to power fans if it gets too hot in the summer. A constant environment is necessary to help my illness.</p> <p>I have a lot more laundry to do - which causes a need for extra electricity/a good washing machine/extra sheets/extra clothes because my dressings frequently leak and have to be washed on a hot cycle as soon and as frequently as possible to reduce the risk of infection and to keep me as clean as possible.</p> <p>I have to keep to a special diet which costs more.</p> <p>My mobility level varies so I need the ability to pay for taxis to get to vital appointments (usually healthcare related) when I am too ill to use public transport or drive.</p> <p>My car needs to be adapted which costs over six hundred pounds. I have to buy nebulisers because they are not available for long term loan or on prescription. I have to buy the leg protectors so I can shower - again they are not on prescription.</p>

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	<p>I have to have more water and energy to heat it because I have to have frequent baths/showers for my skin condition.</p> <p>I frequently have to buy extra dressings because my practise nurse is limited on what she can order and my wounds require special care.</p> <p>I need internet access to keep in touch with everyone when I am housebound by my illness.</p> <p>I have to pay to park in hospitals which is very expensive and I have many appointments so I have no choice but to park there.</p> <p>My illnesses cause my size to change so I have to buy extra clothes (steriods cause weight gain, stress causes weightloss).</p> <p>And finally, my biggest cost is that when I am out of control - I buy things when I am not in my right mind because I have delusions and that can cost a fortune when I have such a limited income.</p>
ONLINE495	<p>1) Little or no reference within the DLA form as to how Autism/Aspergers Syndrome and any other hidden disability, can affect peoples lives especially high functioning individuals. This often leads to an ineligibility to claim DLA which can result in an individual becoming isolated and unable to access all the activities that non disabled people enjoy, partly due to the additional expense of paying for support needs that allow individuals to join in and/or paying for the cost of what can be an expensive activity ( these can be all consuming and may be the only activity enjoyed by the individual). The application process must have the wherewithal to be able to highlight these difficulties.</p> <p>3) Autism/Aspergers Syndrome and any other hidden disability, can affect peoples lives, especially high functioning individuals who also don't meet the Fair Access to Care criteria. The extra cost can be disabling in itself in trying to access a good and positive life, more so for the young adults who find mixing and socialising etc, difficult to do without support but who are classified as too able to meet the criteria for DLA and therefore have to meet these needs out of their own pockets or parents.</p>
ONLINE496	<p>1) Mobility is a major factor. When you are disabled it is impossible to be spontaneos. You have to plan every journey and activity to the last detail. Are there steps, are there suitable toilets, suitable parking.</p> <p>Many activities take much longer to perform so sometimes its difficult to fit in "normal" timtables or cope with change.</p> <p>There are still elements of discrimination, if you cannot walk you must be a bit slow and people still talk to careres rather than the disabled person directly.</p> <p>It is expensive being disabled. You need to buy extra equipment to help and I see a difference between disabled people who can afford quality equipment and those who cannot.</p> <p>If you are going to take into account the equipment people use you will be in danger of making people more depedent, if they view improved equipment equals reduced DLA?</p>
ONLINE497	<p>1) There is still on going discrimination towards disabled people which prevents full participation. Physical barriers are prevalent in many areas and the general population do not automatically consider these when arranging events or understand how limiting these barriers can be to the lives of many disabled people. A large number of disabled people have very limited finances so the additional costs they have in relation to their disability reduce their opportunities and independence even further. The problems finding employment exacerbate this further.</p> <p>Families who care for the person with disabilities may have had to give up working to care for the person so finances are even more restricted. This vicious circle is, at present, assisted by DLA. If it is removed, and targetted only to those with very complex difficulties, a large number of people will lose their independence and have to rely more on other</p>

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	<p>Welfare Benefits or slide into greater poverty.</p> <p>2) The name should be retained as it should be seen as an allowance to help people with the additional, often costly, needs caused by their Disability. It should be aimed at a broad range of needs as it is at present because it is supposed to be promoting independence. Those with complex needs may not reach true independence whereas a small amount of funding can give someone with a lesser disability truly independent.</p> <p>3) Disabled people can face higher heating costs, higher transport costs, cost of additional equipment to assist them, cost to adapt housing, costs to employ people to assist them, additional expense for washing clothes and buying additional clothes caused by their disability. There may be medical costs and expenses attending appointments and treatment.</p> <p>4) Having only 2 rates will make the payments less flexible and will possibly see it being aimed at a small minority rather than assisting a wide range of people. The benefit can still be straight forward but offered to more people.</p> <p>5) Many conditions are known to deteriorate and the individual will not ever improve. It is wrong to insist on reviewing these people as it will waste money when the outcome is already known and cause unnecessary stress to the individual and their families.</p> <p>6) The people with the most complex difficulties require assessment to meet their needs in every way to assist with their problems. However, those people with lesser disabilities should not be discriminated against as funding can frequently make them truly independent. For example, funding can help people get to work but if it is removed, they may have to leave work because they cannot access public transport. This may lead them to having to go on unemployment benefit or access more expensive services.</p> <p>The most essential services will vary from person to person and again this will depend on assessment.</p> <p>7) Questions in the form need to be flexible to paint a picture of all the needs on good and bad days but people should not be penalised for having better days.</p> <p>8) It is difficult for someone else to assess how difficult it can still be for people to get around or carry out daily living tasks even with equipment/adaptations. Walking with sticks or propelling a manual wheelchair can cause fatigue because of the effort involved. The amount of effort for the carer should also be taken into account. Sometimes the individual with the disability is unable to use the equipment without the assistance of the carer. People should not be forced to use equipment. There are many psychological issues around equipment. For example, it may be obvious to others that life would be easier if someone began to use a wheelchair but there may be resistance to this as it is viewed as another indication that their condition is deteriorating and the person is not ready to face that yet. The cost of equipment is another issue. Local Authority and Health assessments can be difficult to access and eligibility criteria has meant that only the most disabled people are getting equipment/adaptations. Another reason why people need DLA to purchase their own equipment. Equipment/adaptations for disabled people is invariably very expensive as private providers charge more to this captive market.</p> <p>10) Evidence from the specialists who work with and know the individual's abilities/disabilities and prognosis.</p> <p>11) Any assessment will be stressful particularly if it is felt that the individual is 'on trial' to see if their benefit can be cut. That will always be the suspicion particularly at reviews if there are an increasing number of people having their benefit stopped. I don't see that the assessment can ever be viewed in a positive light when the decision to award or cut a benefit is the final outcome. How can a fair assessment be made in such a short period of time?</p> <p>Some people will not be able to discuss some issues with a stranger particularly embarrassing issues.</p> <p>People with mental health problems could find it extremely stressful and may need to be seen outwith their home.</p> <p>12) Reviews will always be stressful and in many cases are not necessary as if the condition is a deteriorating one, there should be no need to review. Specialists could be asked to provide evidence without the need for more face to face interviews. Where it is deemed there needs to be a review, it should be as infrequent as possible to reduce the anxiety for those who already have enough difficulty in their lives.</p> <p>?) All the benefits lost would add to the financial burden for disabled people and make places more difficult to access.</p>

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	<p>? ) Any assessments which ask for duplicate information.</p> <p>? ) DLA is helpful to get Vehicle Excise duty relief, automatic entitlement to a Blue Badge, transport reductions and other benefits. These benefits should be highlighted in information when the benefit is awarded.</p> <p>? ) Ever changing needs of children because they are still growing and developing - equipment/adaptations are expensive and frequently need to be changed. Forms need to be flexible to reflect this. Reviews will be upsetting for some children, particularly Autistic children and their families. Transition stages with children are particularly difficult stages.</p> <p>Funding can be essential for families to interact with the community.</p> <p>? ) Straight forward easy to understand explanation of what is required in the way of information. Some examples might be useful.</p> <p>? ) There has been greater emphasis recently on personalisation. This means there should be greater consideration of each person as an individual and how that person can reach his/her potential and independence within the limitations of their condition. As the economic climate worsens and Local Authorities remove funding, people with disabilities are having to fund more and more of their services. DLA is becoming extremely important to maintain independence.</p>
ONLINE498	<p>1) Our advice service works with people who are disabled because of mental illnesses, the majority of our clients have chronic and severe mental illness. Many have been ill for many years and have therefore lived for many years on social security benefits alone. We find that the largest barrier our clients have to participating in society and leading independent, full and active lives is financial exclusion. Living for a long time on benefit levels of income means that our clients have not been able to build up a buffer of income through working and, therefore, are not using benefits to tide them over a short period of no employment but need to rely on them for all living expenses and therefore, their income needs to be sufficiently high to enable full participation. Currently an award of DLA plus the associated premiums in means-tested benefits does go a long way to help long-term disabled people have a reasonable standard of living. The extra costs of living with a disability for our client group are not necessarily to costs of obtaining aids and adaptations or of employing a personal assistant, the level of DLA is not sufficient for the latter anyway. We find that every day expenses are increased because of our clients' situations. For example, many of our clients suffer from anxiety and depression and sometimes from paranoia. They find it difficult to shop around for cheap items and have to shop locally in more expensive shops, for example because their depression leads to a lack of motivation to do anything more complicated or their anxiety prevents them from venturing any further afield. An example is a client with schizophrenia who had to buy a more expensive washing machine locally because he was too anxious and paranoid to travel to the city centre to shop at Argos and for the same reasons was not able to shop on-line or by phone. Many of our clients, because of the symptoms, are not able to use public transport and have to rely on taking taxis. This is very expensive and unaffordable with out DLA.</p> <p>We also find that mental ill-health can prevent our clients from paying as much attention to budgeting as is required on a very low income. The stress of getting into debt is avoided if there is an income that covers more than subsistence, i.e. the current personal allowance of £65.45 per week does not leave any room for budgeting errors. This is particular relevant for clients who symptoms include additional spending when they are acutely unwell. The link between poverty and ill-health has been well established by research therefore, DLA has an important role in mitigating the effects of poverty on people's health. Reducing spending on DLA may be a false economy if the result is an increase in poverty related ill health and thus an increase in NHS expenditure.</p> <p>2) If there are only two rates for the care component of PIP it appears that there will be no equivalent of the lowest rate of the care component of DLA.</p> <p>Many of our clients suffer from severe depression and consequently lack of motivation to care for themselves, including lack of motivation to cook a healthy and balanced main meal for themselves. With no additional help in the form of lowest rate care DLA these clients will not be able to afford the more costly health convenience foods and their health will suffer. Research has shown that there is a link between poor diet and poor health, including depression. Therefore, if withdrawing the lowest rate of the care component results in a worsening diet then money will not be saved, costs will instead be displaced on</p>

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	<p>to the NHS.</p> <p>3) We find that the main costs our client group (chronic and severely mentally ill people) faces are: transport e.g. taxis and bus fares, additional fuel costs because more time is spent at home, additional shopping costs because of an inability to shop around for the best deals, credit for the same reasons, setting up home after hospital discharges, for example a chaotic lifestyle or becoming acutely ill can lead some of our clients to abandon their tenancies and possessions, only having to replace everything again when they have recovered and are discharged from hospital to a new address.</p> <p>4) Having two rates per component instead of three rates for one and two for another will have no effect on the complexity of the benefit. We work with people with chronic, severe and at times acute mental illness, we have never found that people are confused because there are three rates of care component. People are confused about whether or not they fit the criteria for particular rates, that will be the same regardless of whether there are two or three rates.</p> <p>Removing the number of components will reduce flexibility and reduce the ability of PIP payments to reflect the range of difficulties people have.</p>
ONLINE499	<p>1) The idea of a benefit which will meet and individuals needs and address their problems and barriers sounds well meaning on paper.</p> <p>However, the decisions will only be as good as the assessments. This will still be down to the subjective thoughts of professionals. For some disabilities and illnesses there are still opposing thoughts across the medical world e.g. Fibromyalgia, Autistic Spectrum, Dyslexia, ADHD.</p> <p>And what if there are no professionals involved. My son is a young man with Asperger's Syndrome a lifelong disability. When he was transferred to Adult Services Mental Health at 18yrs they could do nothing for him as he is not on medication. Which professional is going to be involved with his assessment? How will you get a picture of how his disability affects him?</p> <p>So the new benefit may not address the problems/barriers that certain individuals will have.</p> <p>In addition the government will be employing the professionals who carry out the assessments and as seen in the case of the Employment Support Allowance, their main aim is to reduce the number of people getting the benefit regardless of the individual's ability to work and get a job.</p> <p>I am sure that this will be the case with the new benefit. It's main creteria is to save money and the rest is to pretend that government is really concerned about the plight of disabled people as second class citizens.</p>
ONLINE500	<p>1) Firstly one's diability be it physical, mental or psychological.</p> <p>Secondly the lack of acceptable accesses on transport and buildings to everyday places.The lack of investment to alter this situation</p> <p>Attitudes held by some "official people" as well as some members of the community.</p> <p>2) Motorability vehicles are a necessity to m,any disabled people as they wouldd not be able to afford the appropriate vehclle adapted or type needed to meet their needs</p>
ONLINE501	<p>1) In a word, government. The fact that the government views all benefit claimants as liars, scroungers and thieves does not help people feel that they even want to participate in society.</p> <p>There is nothing wrong with the current benefits system, other than it's application. The arbitrary way benefits can be stopped without warning, or reason makes living anything approaching a normal life impossible.</p> <p>All this government seeks to do is deprive people of the benefits that they have paid for, and are entitled to. It has no interested in the welfare of the people who have to claim disability benefit. They are just an easy target to divert money for overseas aid so that the vermin in government can feel good.</p> <p>There is nothing good in this proposal for any disabled person.</p>

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	<p>2) Don't believe a word of it. This bunch of b***** have already proved themselves to be lying scum. This is just a plan to get more people off benefits and to reduce payments to those that remain.</p> <p>The one thing that should change is that once disability payments are awarded, they remain in place until the DWP can prove, in a court of Law, that the claimant is no longer entitled to receive them.</p> <p>3) Utility bills are high for the disabled, particularly the housebound because of the 24/7 occupancy. Extra or modified clothing. Legal representation will become an extra expense now that the government have removed access to legal aid for benefits appeals. Don't worry, that won't stop us. You'll just be paying out more in costs every time you lose. Private medical care. As the NHS is cut to the bone, the disabled will have to look to the private sector to stand any chance of staying alive. All part of the government plan no doubt.</p> <p>5) Any condition that cannot be completely cured and is impinging on the persons life should be automatic. The idea that you should have to prostrate yourself in front of the state to receive what you have paid for is wrong! Once an award has been made the state should have to prove that the recipient is no longer entitled to receive it before it can be withdrawn. Not, as the case now is where at appeal the claimant has to prove that they are still entitled. Contrary to English law.</p> <p>7) That's not your job. The patients condition is the responsibility of the health professionals. This is one of the major problems of the current system. Important decisions are made by people with no qualifications in anything.</p> <p>10) Reports from the claimants own health care professionals. The vermin at Atos Origin are lying scum. If you're thinking of using them you going to get sued. As I have already said, having to prostrate one's self at the feet of the state is not on. If I have a condition that a consultant in that area of medicine says is disabling then that should be enough. There is no need for any face to face interrogation. ?) Yes. This site is c***. I've given up trying to submit answers because I'm told I'm going to fast and must slow down. Just about sums this poor country and it's evil government up. See you at the ECHR.</p>
ONLINE502	<p>1) If you are severely Disabled and you trying to follow the health and safety for carers sometimes it difficult to go out for the day because some people need 2 carers.</p>
ONLINE503	<p>1) Costs of transport. Physical Disability. Lack of opportunities. 2) n/a 3) Heating, as no allowance for younger disabled people. 4) Possibly o.k. 5) No, should be based upon certain needs.</p>
ONLINE504	<p>1) Being able to physically access venues and locations, having the funds to be able to do this. Disabled people living in residential care have very limited funds available for personal use, taking Mobility Allowance away from them will eliminate their ability to make choices and participate in community activities. I was under the impression that giving an individual choice was a Government priority but it seems this is not the case.</p> <p>2) DLA should be payable in full to those living in a residential home setting. These are normally those with the most severe disabilities and who need the most help. They have very limited funds for personal use, usually between £20 and £25 per week which is used to cover personal necessities like toiletries, haircuts, personal shopping etc. Government needs to protect the rights of the most vulnerable in society.</p> <p>3) Extra heating costs, costs of adaptations and wheelchairs, specialised transport for wheelchairs. Care costs, sometimes 2:1 support if displaying challenging behaviour, specialist footwear or clothes, continence supplies, specialist therapies -speech /occupational/ physio/, intervenors services, advocacy costs etc</p> <p>4) There needs to be different levels of benefit to account for the wide range in the differing levels of need. Without knowing what the rates will be it is not possible to say if they will provide the appropriate level of support.</p>

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	<p>5) Some claims should mean automatic entitlement to benefit. My daughter is blind, cannot talk, is epileptic and has severe learning disabilities. I do not understand why she should go through an assessment process as surely she has enough problems, and also us in having to deal with these problems, without having to go through a lengthy assessment process.</p> <p>6) You need to look at their disability. Those who are wheelchair bound or who cannot see are dependant on others for basic everyday activities such as just getting out into the community and enjoying activities that are going on. If people with these sort of disabilities do not get support then they are condemned to a life behind closed doors, out of sight out of mind. I thought this was the way things were 60 years ago, are we going to return to this?</p> <p>7) Some conditions such as Parkinson and MS will get worse over time so they will need periodic assessment to see if a higher rate of benefit is appropriate. My daughter is 19 years old now and her condition will not change, she should always be entitled to the full amount of any disability benefit. This should be very apparent at any initial assessment.</p> <p>8) This is a difficult question. It depends very much on the overall assessment and capability of the person. My daughter uses a wheelchair but without someone to push it she would just sit in one place all day, someone else may use a wheelchair and be able to access a variety of locations independently.</p> <p>10) We have mountains of paperwork and assessments regarding our daughter. As I have said in the previous question it is very time consuming and frustrating to have to continually complete forms and copy / send paperwork to various departments. We would much rather take our daughter to see someone who would in a very short period of time be able assess her condition and see her very limited long term capabilities. capabilities</p> <p>11) We would be in favour of this, once again please see answers to previous questions. For those with a severe disability, and their families, this could save time and the time necessity to continually complete endless forms, in many cases duplicating information.</p> <p>13) Higher penalties for not informing the Department of changes, more face to face meetings for those who have a condition or disability which is not long term or is likely to change.</p> <p>?) It should be possible to assess a person through one process for all benefits, this is particularly the case when the person has a severe disability. It is frustrating for the disabled and their carers to continually have to complete forms which in many cases duplicate questions and information.</p> <p>?) No comment on this question.</p> <p>?) People need help with completing long and 'wordy' forms and the current application form falls into this category.</p> <p>They also need to know if they can claim if they have a shorter term disability and what happens if their condition changes. Disabled people and their carers are often worn down by the system and yet another form is a major obstacle for them. There is a real danger that those who need the help the most will not get it - the system beats them. But those who do not really need the help beat the system.</p> <p>?) The disabled should have access to other grants to fund either 1 off or on-going aids &amp; adaptations. Why should a disabled individual have to sacrifice part of their PIP when others in the same payment category-but different need do not have the same need for the aid? It is assumed will be the same fixed inflexible amount for each category of need.</p> <p>?) There could be a major impact. If someone lost their PIP payment they could also lose other benefits and services. For some individuals this could have a disastrous effect on their lives.</p> <p>?) There should always be the option to access advice and support.</p> <p>?) We are particularly concerned about the proposals to stop the payment of mobility allowance to those living in a residential home. We assume that this would also apply to the mobility element of any new PIP.</p> <p>Those living in a residential home only have a very small amount of money to meet their personal expenses, usually between £20 and £25 per week. This has to cover items such</p>

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	<p>as toiletries, clothing (in many cases), haircuts, Christmas / Birthday presents etc. If the mobility element is cut then how are they going to access the community? They will have no money for bus / taxi fares, going to the cinema or to a sporting event.</p> <p>It was our understanding that community access and choice was a key element of government policy, if this is the case please can you tell us where the money is going to come from to enable people in a residential home to exercise choice.</p> <p>In a recent letter from Maria Miller that was copied to us she again pledged the governments commitment to choice and community access / integration. In the same letter she stated that the local authority has a duty to carry out an assessment of needs which may include mobility. Local authorities will not assess a need for someone to go to a sporting event but surely this an example of a person exercising their choice and community access €“ stop mobility payments and you are stopping these people enjoying these activities and condemning them to a life behind closed doors. Surely there is a clear contradiction here, the minister is on one hand talking about choice and states that the local authority will assess the persons mobility needs, please can you explain where the choice comes in. People can only exercise choice if they have the means to do so, and if mobility allowance is withdrawn they will have no means to exercise choice.</p> <p>With both local and national government aiming to save money the real danger here is that the severally disabled who live in residential homes will be the ones squeezed in the middle, is this protecting the most vulnerable in society? What will the government do to avoid this? ?) When assessing children you must remember that their condition is more likely to change as they move through childhood. Hopefully this will be for the better but sadly this is not the case with many children.</p> <p>Also aids and adaptations supplied to children often need replacing more regularly as the young person outgrows them leading to additional expense.</p>
ONLINE505	<p>1) 1. The actual disability. It is unreasonable to expect all disabled people to be independent and active, but they can be helped to live the best life that they can.</p> <p>Disabled people need every support in this: with communication, transport, personal care etc ?) Helpful, but could be a lot better</p> <p>PIP could provide a passport entitlement like a bus pass or similar 2) DLA must be open to all who need it. I am concerned that cuts are being directed at the most vulnerable in our society. ?) Much more difficulty! Life is hard enough for disabled people without more administration 3) A multitude. Basic requirements such as food: more expensive to buy prepared foods, energy; need more heat etc</p> <p>water costs, clothing needs more frequent washing and replacing. Difficult to carry out simple household tasks and need to pay for help for cleaning and simple maintenance and repair. Aids needed to help cope. Transport.</p> <p>Help with shopping. Replacement bedding, seating etc etc ?) Why not a one-stop assessment? 4) As long as criteria are fair and understandable and granted appropriately (not according to quota) should be fine. 2 levels may be a crude application for a subtle difference in needs. 5) I would think that certain conditions should automatically entitle.</p> <p>How can a benefit be said to be fairly applied to needs and circumstances. Those with communication problems eg autism, cannot adequately communicate their difficulty.</p> <p>how can an adjudication officer genuinely assess the difficulties without immense knowledge of very private details of life.</p>

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	<p>Condition would appear to be more fair measure. 6) Feeding- cooking and eating</p> <p>Bathing Dressing Some degree of mobility A right to pursue an interest If that person is genuinely unable to work: acceptance and respect, not vilification 7) Pro rata basis? 9) Make the experience more positive by counteracting the process of vilification of claimants in the tabloid press, which appears to be a product of the current consultation. Ask more specific questions. Ask for illustration of yes answers Educate GP's and Health Professionals about eligibility (I understand there is confusion): and give credence to their reports Consultant confirmation</p> <p>10) Health Professionals/ Support Workers Supporting information from carers</p> <p>11) If the healthcare professional is not hampered by quotas and ticklists and can give an honest professional assessment this is fine. Benefit should be awarded by need. Communication problems will need to be overcome. A home visit could be intimidating (from both perspectives!): a neutral venue may not cause bias, and be better for both parties</p> <p>12) If a condition is lifelong, award should be for life Certain disabilities worsened by stress, which reviews can bring. this should be taken into account Reviews should be tailored to need of individual</p> <p>13) Bi-annual review/ copy of last statement sent out with written request: if there are no change in circumstances, that statement confirmed by a GP, should be sufficient. Comparison form could allow changes to be shown: better or worse? Cumulative differences could necessitate reappraisal.</p> <p>14) A leaflet ticklist accompanying application form would be helpful - written in simple form. 15) Health Professional Advice. National Charity Telephone line with unbiased advice 16) No 17) Condition based more than adult: it is distressing for parents to rehearse their child's disability</p>
ONLINE506	<p>2) Those who have received a letter often many years ago stating that their DLA was for life should not have to undergo a medical or be interviewed. The DWP should stand by its commitments. 9) The claim form should be on-line only. There should be clear examples of those who do not qualify to stop people building up their hopes. ?) PIP should be means tested. All non-contributory benefits should only be for the poor.</p>
ONLINE507	<p>2) Making people with disabilities that are never going to improve go through regular assessments is needless. It puts a strain on those people, adds to their costs, does not reduce the benefits payments and adds considerably to the overall costs. Especially in bringing in health professionals to question the views of other health professionals made only a year earlier.</p>
ONLINE508	<p>1) Mobility and physical access. British Standards institute stipulates that a wheelchair ramp should not be steeper than 1 in 12, many streets in the UK exceed that and they have uneven surfaces or wheelie bins and the like preventing disabled access. It is not possible to step over obstacles such as pot-holes in a wheelchair. 2) Who decides if it should be awarded should stay the same. 3) Travel, even short distances, even if you have a wheelchair. 4) Not sure, depends how it is presented. will it be more expensive?</p>

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	<p>5) If the condition is progressive or there is no known cure or means of improving why incur the extra cost? If you don't have any legs you are not going to grow a new pair are you?  5) That they are children. They may not understand their needs or what is done for them and why.  6) You don't 'priorities', all disabled people equally need support, some need more support than others. Communication, home help and travel are what is needed.  7) For conditions that get worse the person can inform their GP and the DWP. If they get better the GP can inform the DWP  8) No. The assessment should be of the disability not if the person chooses or can use high-tech equipment or not. There is some very expensive equipment that is not available to everyone and not everyone can adapt to use it.  10) The supporting evidence is the individual with the disability, if you use specialists in the disability to assess the individual the disability will be the truest evidence. If you choose to use so called 'independent specialists in health' who do not have specialist knowledge of the disability and the patient then the you may not get a 'fair' result and will be open to question.  11) A difficulty would be if the 'healthcare professional' does not have experience of patients who have the specific condition being assessed. No point sending a GP to assess someone with MS, you would need an MS specialist.</p>
ONLINE509	<p>18) DLA has been VITAL in getting access to the entitlements.</p> <p>Blue Badge Scheme is imperative for independence and being able to get to services and facilities.</p> <p>Motability provides access to vehicles (ones big enough to transport wheelchairs or adapted to meet the users needs) and wheelchairs / scooters that mean disabled people can be independent and lead active lives. If being able to access this is lost it will have a devastating impact and will affect people being able to get to work, access the community, shop, go to hospital appointments etc.</p> <p>Think maintaining these passports should be a priority.. according to the above proposals a wheelchair user may lose their mobility allowance which in turn means they'd lose access to Motability and not have a car. This does not promote independence or allow the disabled person to live an active life!</p> <p>1) Lack of money for equipment and maintenance of equipment.  Lack of funds/resources, long waiting lists and too tight eligibility criteria for government funded equipment leading to people self funding equipment.  Attitudes and lack of insight of press, public, MPs and others.  Inaccessible transport, services, shops and recreational facilities.  Lack of suitable housing.  Poorly funded social service/care system.</p> <p>?) Think it will have a negative impact on people with disabilities. I think people with a current genuine need as identified by DLA will lose out despite still having the same need. I think it will have a negative impact on people on working age and due to the proposed stricter criteria the inevitable withdrawal of the benefit from some people despite their continuing need will impact this age group and even decrease employment.</p> <p>2) The impact would be extremely negative and devastating.  It would decrease independence, mobility, choice and being able to lead an active life. People would miss out on benefits and services they're entitled to. Poverty amongst the disabled could increase and employment decrease.  It would also be extremely stressful and confusing if disabled people had to keep being assessed and applying for different benefits and services instead of DLA passporting to services like Motability, Blue Badge Scheme, benefits etc.  DLA as it stands has a thorough assessment which is why it can be used as a passport to other services and benefits. This should be respected and maintained.</p> <p>2) Think it should all stay the same, the 3 care components, 2 mobility components, not taking into account wheelchairs/aids/adaptations and not withdrawing mobility allowance for those in hospital / care.  With its low fraud rate it seems to be working well.  ?) Could share care plans from Social Services and Care providers as long as permission is sought from service user. Although I think this should be alongside GP medical reports</p>

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	<p>not instead of.</p> <p>As DLA is not an out of work benefit and the proposed PIP won't be I do not think it is appropriate to include the ESA assessment as this is assessing different needs and is relevant to employment.</p> <p>3) Too many to log here and obviously it varies greatly person to person, however some examples are:</p> <p>Aids / adaptations / mobility equipment eg wheelchairs.</p> <p>The maintenance, repair, insurance and servicing of the above.</p> <p>Extra travel costs for appointments or having to travel further to find an accessible service, facility or shop.</p> <p>Extra travel costs due to having to find alternatives when the nearest or cheapest option is inaccessible such as a taxi instead of a bus.</p> <p>Care costs.</p> <p>Special diets or clothing costs.</p> <p>Call aid costs.</p> <p>Extra car costs as a bigger car maybe needed to transport a wheelchair/equipment or a car may need to be adapted.</p> <p>4) Quite simply no. The 3 rates system recognises that the multitude of disabilities and the needs stemming from them vary greatly. Two rates will be too narrow and appropriate levels of support will not be met. The disadvantage is people with needs may not get the appropriate support and this could impinge on their independence and choice.</p> <p>5) I don't feel I have enough medical knowledge to comment on the above properly however it seems obviously that those with terminal or severe needs should have automatic entitlement.</p> <p>6) Make sure the support covers a wide range of activites and does not just consider one or two basic activities.</p> <p>Personal care.</p> <p>Toilet needs.</p> <p>Meal preparation.</p> <p>Feeding.</p> <p>Transport.</p> <p>Accessing medical facilities and appointments.</p> <p>Access to shops/services.</p> <p>Access to the community / socialising.</p> <p>7) The new assessment should be based on how the applicant is when their needs are at their greatest eg their 'bad days'. A piece of equipment or support has to be available all the time even if a condition fluctuates as there is rarely notice of a 'bad day' or 'bad patch' so the extra-costs remain always present.</p> <p>8) No. This is one of the most worrying parts of the proposal.</p> <p>Wheelchairs should NOT be included. Just because a person can mobilise in a wheelchair does not mean their mobility is then on par with an able bodied person. The wheelchair in itself is an extra cost and the ongoing maintenance, servicing, repairs and insurance incur extra costs. This is what the benefit is supposed to be there for. Plus using a wheelchair leads to extra costs for transport if the cheapest or nearest option is inaccessible. Our environment still has many inaccessible aspects to it and therefore a wheelchair user may have to travel further to access facilities, shops, jobs and services thus again incurring the extra - costs DLA is there to help with. Taking into account a wheelchair in an assessment will have a devastating affect and will negatively impact on the independence and choice of disabled people.</p> <p>Many other aids / adaptations also require maintenance, repairs etc such as toileting equipment, alarms.</p> <p>To clarify I do not think the new assessment should take into account any extra actual or possible aids or adaptations to what the current assessment does.</p> <p>9) I do not think it can be made simpler. It needs to be thorough, if it is too basic it will not cover all the relevant needs or various disabilities. I think it is impossible to make it a positive experience, whilst focusing on the negative is hard it is ultimately the things that someone can not do that lead to the need for DLA. A person maybe able to plan a journey, brush their hair and clean their teeth but these are irrelevant if they can not independently have a shower or get dressed.</p> <p>Second point - leave DLA as it is, changing it is going to cause the confusion.</p> <p>10) The people most involved in the applicant's care are best placed - GPs, Consultants,</p>

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	<p>Physiotherapists and other relevant medical experts. Social services and carers. These people should provide the primary evidence.</p> <p>I think an 'independent healthcare professional' should only be involved if they are TRULY independent eg not being target driven or rewarded by the DWP. Plus they must have experience of the disabilities and needs they are presented with such as physical needs or mental health needs not just 'general knowledge'. I also think any independent healthcare providers should be monitored and thoroughly researched by the department and independent disability charities before being employed by the department to ensure fairness.</p> <p>11) To clarify some current DLA recipients have already had face to face meetings with a healthcare professional, this is not new.</p> <p>Difficulties - healthcare professional may not have sufficient knowledge of the disability and needs, a meeting is not representative of everyday life, time restraints may not cover everything and fluctuating conditions may be assessed wrongly if person has a 'good day' on day of meeting. Impartiality may be compromised if Healthcare professional has targets to meet or is rewarded for meeting these targets.</p> <p>Benefits - possibly reduce fraud HOWEVER I doubt this as the DWP statistics already show that fraud rates for DLA are very low so this is unlikely to be reduced any further.</p> <p>Point two - when it is obvious from current medical notes that the disability and need is genuine (surely a waste of resources and funds having the meeting), when they have already had a medical assessment with DLA and deemed to have a long term ongoing non improving need, when someone is terminally ill or is unable to leave their home due to dialysis or severe needs etc.</p> <p>12) Carry out reviews by checking medical notes.</p> <p>If someone has a long term condition that will deteriorate or not significantly improve then the reviews should be infrequent if at all. This can be easily checked by accessing someone's medical notes...if they continue to have the same medication or treatment etc as when they applied it is unlikely anything has changed.</p> <p>It seems pointless to regularly review someone who's needs and disability are not going to significantly improve. If someone has just a one off problem that could get better then review them. It could be a waste of public money to keep reviewing people with non curable long term health conditions.</p> <p>13) Judging by the low fraud rate I am guessing that it is only a minority that do not keep the Department informed and changing DLA to PIP isn't going to alter this. It is already clear in DLA information and letters that changes need to be reported, if someone decides not to report something changing the benefit is unlikely to change the attitude. I do not feel there is a problem with understanding DLA.</p> <p>14) I think advice and information should be available at all times regardless of whether it is DLA or PIP. It should be sent out automatically but not be a replacement for the benefit just an added extra.</p> <p>15) If it is a minority of claimants who don't take action then making it a requirement for everyone seems unfair. Plus the advice and support needs to be adequately funded. Many people use their DLA to access the support.</p> <p>Need to avoid people being 'palmed off' with 'advice' and unattainable support instead of getting the benefit they need to cover extra costs.</p> <p>Plus who decides what advice and support is appropriate to whom? Will the person making this decision be properly trained?</p> <p>16) Many disabled people self fund their aids / adaptations due to long waiting list, too limiting eligibility criteria, lack of funds, resources and suitable choice for government funded aids / adaptations. This is not going to improve with current cut backs.</p> <p>Unfortunately a one off cost won't cover the ongoing maintenance, repairs, servicing and insurance of the aids and adaptations that many people rely on their DLA for. It also won't cover other extra costs mentioned earlier such as extra expense finding accessible transport, services etc This will not work and leave people struggling to cover the cost of the upkeep of their aids and adaptations.</p> <p>17) Impact on other family members.</p> <p>Pressure on parents / care givers.</p>
ONLINE510	<p>3) Taxis, heating, carers, food, aid and adaptations.</p> <p>4) Don't think it will make benefit easier to understand or run. Reducing from three to two rates for the Care component could mean a reduction towards the lower level with people currently on the middle rate being rounded down.</p>

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	<p>5) Yes some conditions should qualify automatically, ie. spinal injuries. Individual needs should be taken into consideration for benefit since conditions and symptoms can vary so much between one person and another.</p> <p>6) Initial referral could be from the persons G.P. or Consultant. Be able to move around without obstacles. Personal hygiene. Adaptations being made timidously to homes</p> <p>8) No, aids &amp; adaptations should not be taken into account since they differentiate a person from others &amp; can often cost a disabled person dearly.</p> <p>9) Less questions more space for details. Make sure health professionals are aware of the benefits &amp; get them to discuss with people who come into the criteria for it.</p> <p>10) G.P. or Consultant in association with the person themselves. details of physical &amp; mental capabilities from G.P./ Consultant</p> <p>11) It could be totally subjective, since the person consulted does not have a day to day contact with the person. If someone has good and bad days with a fluctuating illness this may not be taken into account. It may affect the level of benefit awarded.</p> <p>12) If a condition fluctuates it should be looked at more frequently. If the condition is chronic and static and has been for years there is no need for frequent reviews.</p> <p>13) Many people who are chronically ill will be unable to tell you of changes &amp; would be dependent on advocates doing this for them. As at present people who are honest will tell you of changes for the better or worse of their condition but there will always be a minority of people who will tell you nothing and try to have no contact with you.</p> <p>?) All information should be shared between government departments - it would cut down on abuse of the system and highlight discrepancies quicker. The information should not be shared with outside agencies without the persons written permission.</p> <p>?) DLA has opened up many avenues for people to be more independent ie. Motability, Independent Living Allowance etc.. The information booklet issued with DLA gives advice on other benefits and or services the person may be entitled to. If people didn't automatically get help from these other benefits it would mean they would have to apply for everything individually thereby making the system more complicated not easier. Those most in need would probably miss out. If they miss out on services their independence is compromised.</p> <p>?) Many people have to either try to save &amp; pay for adaptations or depend on charities or associations helping them to cover costs or supply equipment. Yes the benefit should be allowed to pay for one-off costs. If it is ultimately going to be of benefit to the person and give them more independence/ reduce pain etc..</p> <p>?) Many will need clarification on what sort of health changes should be reported to you. Yes it would help to be told where to get advice.</p> <p>?) The most vulnerable would miss out on services and benefits that would improve their quality of life. It would be a negative step taking us back to the situation we were in before DLA was introduced. DLA was introduced to try to improve the situation of linking services and benefits so there is no point in going back the way.</p> <p>?) The situation for children would usually change more often than for adults. As the child grows additional cost will be incurred.</p> <p>?)</p>
ONLINE511	<p>1) Occasional or frequent or continuous or virtually continuous inability or partial inability to perform some task or tasks by virtue of some diagnosed or undiagnosed disability that the person would expect to accomplish if they were not disabled. The task is anything from breathing to marathon running, it depends on the person. Some I have personal experience of are - Communication for those who stutter or are frightened or partly deaf. Management of medication for those less stable diabetics who need someone to keep an eye on them. The need to have a companion virtually continuously in case an occasional emergency arises. The need to be checked frequently and be woken by a companion in the night 3.30am to perform medical procedures where the disabled person can be too deaf to hear an alarm and too unwell to respond to a vibrator themselves. Also:Lack of money.</p> <p>2) Payment is not linked to cost of particular aids, but is awarded on account of having a</p>

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	<p>disability. Not means tested means don't reduce payment if there are earnings. No re-assessment unless circumstances are declared as having changed. Watching over the disabled by a companion, and other "help from Others" needs retaining. The person "can do with help" needs retaining. Some health conditions eg. deaf-blind to maintain automatic approval. Subjective assessment remains inevitable unless comprehensive information is collected. The information provided for DLA assessment is not used for any other purpose.</p> <p>3) It's not about costs, although it's measured in costs. Somewhat unstable diabetes - means no driving licence means no driving employment means no employment - the disability causes almost complete lack of income, this can be seen as a cost when compared with what others may earn, and should be replaced by benefits by virtue of the disability not by showing costed receipts. There are of course costs of household adaptations, various aids, taxis, paid companion, etc, etc but the particular magnitude of these costs need not reflect or relate to the degree of disability and it is the latter that is being awarded benefit.</p> <p>4) OK, but do keep this under review with input from disabled representative bodies. There may be problems in selecting and assessing the key activities and in determining the qualifying levels for each.</p> <p>5) It is arguable that short term disabilities should qualify eg. taxi hire to get to work while a broken leg heals, please consult disability organisations about this. The "qualifying period" must be back-dateable and not act only as a waiting period from the date of application. Some variable conditions can impose the same disabling consequences as more persistent conditions, for example, a paid companion has to accompany and be on hand to assist with unpredictable frequent emergencies caused by the condition, please consult disability organisations about this. Automatic passporting of benefit according to certain conditions needs retaining, there's no point formally assessing a deaf-blind person as to mobility problems, you already know the answer from the diagnosis.</p> <p>6) Focusing support on "those who need it most" will leave behind the others who still need it but not so much, or so often and they should not be left out - setting the cutoff between the two is not an issue to be settled by politicians, please consult with disability organisations about this. An "individual's specific needs" is something that is subjective by the information provider, often the individual, and is subjective by the assessor who would each have their own opinion about How many times in the night, or How far away the local shop needs to be. Specific questions, counting up points, applying rules, will only take you so far, there are relevant topics that will be missed by a prescriptive objective system. It is subjective at some point and will fail in its aim if this is ignored. What's important to me may not be important to you so where is the objective truth to be found? Variable conditions need assessing at their "worst case" state and be adjusted for frequency - Like this example: Something that is severe when it happens (high rating) but not happens often (low adjustment) never the less gets a high assessment because a carer has to be present most of the time (high implied cost). The list of activities is badly chosen, and I say that with confidence regardless of how the list is chosen because it can't be this prescriptive if it is going to work. Please consult disability organisations about this.</p> <p>7) What's important to me may not be important to you so where is the objective truth to be found? Variable conditions need assessing at their "worst case" state and be adjusted for frequency - Like this example: Something that is severe when it happens (high rating) but not happens often (low adjustment) never the less gets a high assessment because a carer has to be present most of the time (high implied cost). Some variable conditions can impose the same disabling consequences as more persistent conditions, for example, a paid companion has to accompany and be on hand to assist with unpredictable frequent emergencies caused by the condition, please consult disability organisations about this.</p>
ONLINE512	<p>1) There needs to be a recognition that for some severely mentally disabled people independence will be measured in very small steps and that an 'independent' life for someone with severe learning disabilities and autism may look very different from the average life that most people lead. I think is it becoming a rather glib mantra, rather like the old normalisation theory, often perpetuated by those who have no idea of what</p>

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	<p>independence for someone with severe learning disabilities actually looks like. Leading a full life does not mean being independent in daily living skills.</p> <p>My son will never be independent in daily living skills and requires care and support in all areas of his life. Providing him with a sense of independence is hard and relentless work which revolves around trying to encourage him to make choices. Any activity or outing takes days of preparation with no guarantee that he will cooperate in leaving the house or joining in the activity once there. Flexibility is key in his ability to be able to participate in society and in being active and is often the key missing factor to supporting his participation.</p> <p>It can be difficult to participate because for example, many societies and clubs want regular attendance and this level of consistency is difficult for my son and us as a family to achieve. Finding local non competitive sports opportunities for the learning disabled is impossible and like many learning disabled swimming is the major source of exercise. However most swimming pools put the 'disabled session' at the most inaccessible hour of the day or on a Sunday. What more evidence is needed of the lack of interest in providing for the needs of the learning disabled.</p> <p>Having any opportunity of being active relies heavily on having a car for transport and DLA is vital to being able to achieve this.</p> <p>Things like more visual /pictorial displays and more people within society with basic simple signing such as Makaton would all help to make us feel more welcome and provide my son with that sense of being included.</p>
ONLINE513	<p>1) The biggest barrier is discrimination and discriminatory practice. Many people assume that people with disabilities are not able to contribute to society. However, the reality is that, if the correct support (including financial support - living with a disability is very expensive!) is in place, they are able to contribute.</p> <p>Another problem is accessibility - physical and emotional/psychological, depending on the person with a disability's needs. Quite apart from not being able to take part in society, denying someone access hurts - they feel rejected.</p> <p>More recently, another barrier is the media's negative portrayal of people with disabilities. They are now often seen as scroungers, when the truth is usually the exact opposite. This form of wholesale character assassination is not constructive and unnecessary - the DWP states that DLA fraud stands at only 0.5% (the second lowest fraud rate ... the lowest being the State Pension). You will always get 'professional criminals' claiming benefits; it's no reason to tar all people with disabilities with the same brush.</p> <p>2) There should definitely be no upper age limit. The disability doesn't disappear when you reach a certain age and so the needs of that person will still be the same €! if not more, because of increased age.</p> <p>By limiting the upper age limit, you limit the age at which the person with a disability can work (and contribute to society). You will also take away many benefits that are associated with DLA/PIP €" this would probably have a considerable impact.</p> <p>The automatic entitlements should stay the same as people who already have this entitlement have a substantial disability that, as research has found, deteriorates over time.</p> <p>3) The expense of paying for and employing carers.</p> <p>The expense of staying mobile.</p> <p>The expense of paying for adaptations €" both major and minor.</p> <p>The expense of wear and tear on clothes, furniture and fittings.</p> <p>The expense of paying someone else to do odd jobs for you.</p> <p>The list, quite honestly, is endless.</p> <p>Imagine breaking both legs and/or having flu €! then imagine having to function €! it's not similar, but it gives a vague idea of what it's like €! and we live with it all the time.</p> <p>4) No, I don't think it'll make it easier.</p> <p>Having a range of levels of benefit allows for decision makers to more accurately place a person in the correct category. The current system is suitable.</p> <p>5) Yes, of course some disabilities should have an automatic entitlement.</p>

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	<p>Disabilities such as bilateral lower limb amputations or muscular dystrophy are not going to get better . In fact, research has found that their health needs will deteriorate. It is a waste of tax payers money to continually assess someone whose disability is obviously significant. It also causes unwanted stress to the person with a disability. I would go so far as to question whether frequent assessments could be seen as harassment or breaching a disabled person s human rights?</p> <p>6) In no particular order: eating, drinking, toileting, sleeping, getting dressed and undressed, walking, moving around the home, sitting, making meals and drinks, dressing/undressing, moving around outside, shopping, cleaning and tidying home, enjoying family life, sex, working, leisure activities.</p> <p>7) To best ensure that the new assessment appropriately takes account of variable and fluctuating conditions, you need to listen to the person with the disability (and hear their needs). And, you need to listen to their GP and their (often various) medical/surgical consultants €“ these people know the person with the disability the best as they have treated them and they know their limitations €” etc.</p> <p>Having regular assessments by someone who has no knowledge of the person is fruitless, in my opinion, and suggests that the true needs of the person aren t the most important consideration.</p> <p>7) It would be very time consuming as you would have to search out what you were entitled to. And, you would have to provide medical information to a variety of agencies. Not having passporting would mean that people with disabilities would be out of pocket, by a considerable amount of money.</p> <p>8) You need to be aware that aids and adaptations do not always work €“ they can break or wear out.</p> <p>Even with an aid or adaption, people will not be able to perform as an able bodied person does. In the case of a physical aid or adaption, there will be wear and tear on the person s skin, soft tissues and joints. In the case of an amputee, they will (usually) have problems with socket fit and they will develop (this is supported by research) arthritis, osteoporosis and osteopenia €“ compared to the able bodied population, amputees are considerably more likely to develop these conditions.</p> <p>There is currently a prosthetic treatment postcode lottery in the UK. Some Centres can supply high tech components and provide good fitting sockets, but many Centres can not. In the case of amputees, it is unfair to expect everyone to run like Oscar Pistorius. Most amputees are over 65 years and are already in very poor health. Fifty percent do not walk. Younger amputees have many problems getting good socket fits. An amputees activity is very variable - it isn't uncommon for an amputee to walk a certain distance one day, then they need to rest the following four days.</p> <p>The assessment should assess the person properly and so they should be able to tell the person with disabilities what other aids are available. This means that the person who assesses should be a fully informed professional (i.e. an OT).</p> <p>9) The claim form is fine as an initial claim form. However, a subsequent claim form (to assess further needs at a later date) needs to be much shorter.</p> <p>I think most people know who the benefit is for and what it is designed to help with (e.g. care needs).</p> <p>You could make the experience more positive by listening to the person and getting advice (on the person's condition) from their GP and the medical professionals who treat them.</p> <p>9) The biggest impact will be on people who currently have automatic entitlement to DLA. As these people have significant, long-term disabilities that will not improve over time, it makes no sense for them to loose automatic entitlement.</p> <p>For example, double lower limb amputees, despite prosthetic high tech components will ultimately develop arthritis faster than a none-amputee. They will also develop osteopenia or osteoporosis on the amputated side, because the residual limb does not weightbear through the bone. They are more likely to develop osteoarthritis in the spine. As they usually also use a wheelchair, they will be more likely to develop arthritis in their upper body. As they are missing most of their legs they will be more likely to develop heart problems. It is unfair to expect a person with a significant disability to undergo frequent assessments. It is also a waste of money.</p> <p>These arfuments could be applied to any person with a physical disability who is currently automatically eligible.</p> <p>Also, frequent assessments on anyone with a disability will have a massive effect on them.</p> <p>10) Assessment of ability does not take into account the effect that activity has on a person</p>

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	<p>in the long-term. To adequately assess someone, you should also take into account all the research surrounding that person's disability/condition.</p> <p>The people best placed to provide this information are the person's GP and any consultants or healthcare professionals that treat their disability/condition.</p> <p>10) I urge you to listen to the charities that support people with disabilities. They understand what it is like to have a disability.</p> <p>11) If the face-to-face contact is performed by someone from Atos (or a similar company) I foresee many more problems than benefits!</p> <p>If you wish to adequately assess someone's (dis)ability you should listen to the person, listen to the GP and listen to any consultants that may be treating them. These people will have a better understanding of that person's ability than anyone else, especially if the condition is rare or complex.</p> <p>Relying on a 'snap shot' examination by a healthcare professional, who probably doesn't understand the condition, is unfair, expensive and counter productive.</p> <p>It would be unnecessary to have a face-to-face consultation if the person has a terminal illness or if you have already decided that someone will receive DLA/PIP because they have a long term condition that is significant and complex.</p> <p>12) If a person has a 'new' disability then they should be reassessed after a year and then reassessed after three years. After that, if there is no change or a deterioration they should not be assessed. If evidence is needed then, the person's GP or consultant should be asked to supply evidence.</p> <p>If the condition is rare, complex or terminal then there should not be frequent assessments. Frequent assessments are invasive, stressful and expensive. These people should have automatic entitlement.</p> <p>13) DLA has the second lowest rate of fraud of any state benefit (i.e. 0.5%), which suggests that the problem isn't as widespread as this document states.</p> <p>People with disabilities can perform well one day and feel absolutely dreadful the next day. There needs to be greater flexibility in this benefit, not less.</p> <p>14) Why reinvent the wheel? There are already OT's and the Independent Living Centres who provide advice on a wide range of disability related issues. The government should invest in these areas.</p> <p>15) The Independent Living Centres already provide this type of advice. There should be more of them, and they should be invested in and promoted.</p> <p>16) They usually fund them themselves.</p> <p>The DLA is very welcome and essential, but it is insufficient to fund all a disabled person's aids and adaptations. An optional one off cost (in addition to the standard PIP) would be very helpful.</p> <p>17) Children often need carrying, especially if they have behaviour problems or they have had surgery. Children also often have siblings, which the parents need to care for at the same time as the child with the disability.</p> <p>You should not rely on outside agencies to provide the additional funding.</p> <p>18) DLA 'passporting' has been absolutely essential! It should be extended.</p> <p>20) I have nothing to hide, so I do not mind which agencies share my information, as long as I am aware of who my information is shared with.</p> <p>I have a significant disability that will deteriorate over time (e.g. my joints are abnormal, so they will age faster than other people). Anything that will help me, by helping financially and by minimising paper pushing will help me and will be much appreciated.</p> <p>?) DLA has the second lowest rate of fraud of any state benefit (i.e. 0.5%), which suggests that the problem isn't as widespread as this document states.</p> <p>People with disabilities can perform well one day and feel absolutely dreadful the next day. There needs to be greater flexibility in this benefit, not less.</p> <p>?) Why reinvent the wheel?</p> <p>There are already OT's and the Independent Living Centres who provide advice on a wide range of disability related issues. The government should invest in these areas.</p>
ONLINE514	<p>1) Society's attitudes to people with learning difficulties prevents many of them to access paid employment. Many people with disabilities need extra support to enable them to participate in ordinary activities or employment. People with fairly mild learning disabilities are prevented from achieving because they cannot gain employment yet their benefits do not allow them to live independently.</p> <p>2) automatic benefits should be paid to people who have severe and complex disabilities</p>

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	<p>which cause them to need full-time care or disabilities or illnesses which are proved to be life-limiting</p> <p>3) people often incur extra cost owing to their condition preventing them to move about independently - extra heating costs, laundry costs, delivery costs, equipment costs, continence products, travel costs, personal assistant costs etc. people with Autistic spectrum disorders or other developmental disorders often find it difficult to go out independently and need the support of another person to keep them safe from harm. people who have these conditions are unable to assess dangers and need constant supervision. extra costs are incurred when people need to buy in support or need to use taxis.</p> <p>5) there are certain disabilities which are life-limiting and extremely debilitating which should make people automatically entitled to benefits. A list of conditions should be made available and only people who have been properly diagnosed should get the automatic benefits. All other claims should be assessed on the impact of the disability - for example there are different levels of impairments for those people who suffer from Arthritis, back conditions etc. also some people who suffer from multiple conditions are often extremely debilitated by the combination of symptoms.</p> <p>7) By ensuring applicants are being monitored by medical professionals for lengthy periods - fluctuating conditions are debilitating even when they are not badly affected as there is an uncertainty about how long the respite will last. People with these types of conditions often make adjustments to their lifestyle to accommodate their symptoms. People who have these conditions should be monitored regularly by consultants or specialist nurses etc therefore these professionals should be consulted as part of the process of assessment. It is rare that fluctuating conditions would leave a person without any symptoms at all and when they flare up they are often very debilitated by the symptoms which can significantly affect their ability to remain in work - therefore the support of the professionals is paramount for these claims</p> <p>8) aids and adaptations enable people to function more easily but they do not necessarily enable full participation in activities. Even when using wheelchairs activities are hard to access owing to lack of appropriate facilities therefore having a wheelchair does not ensure that people can achieve the same outcomes as able-bodied people. E.g in the recent bad weather people in wheelchairs were totally restricted from going outside if there was snow and ice as wheelchairs cannot grip in these conditions.</p> <p>9) different assessment forms could be used so that they are adapted for different types of conditions e.g. physical disabilities, medical illnesses, mental health conditions, etc and people who suffer from a mix of conditions could fill in a number of forms which are relevant to their conditions. Alongside these forms there should be parts which are filled in by relevant professionals or should have supporting documents included which indicate the impact of the disability on the person.</p> <p>10) forms could be produced which the relevant consultants/specialists can easily fill in to support applications. in the case of children professionals involved with the children could fill in relevant parts of the application.</p> <p>11) this would benefit many applicants but in the case of people who have mental health conditions including ASD, ADHD, Bi-polar disorder etc may need support to enable them to understand what they are being assessed for or to help them cope with any questions. Children would be best assessed in a familiar location but not always at home depending on their behaviour patterns.</p>
ONLINE515	<p>1) The answer to this depends on the actual disability and will vary from one person to another. Not all disabled people face the same challenges. Yet again you are trying to pigeon hole people and in doing this it will undoubtedly impact negatively on some disabled people. The answer to this question is impossible to clarify except on an individual basis. A daft question!</p> <p>2) To have reviews of a disabled persons needs on a regular basis is going to be costly and ineffective. Some lifelong conditions remain the same throughout a persons life and DO NOT Change. EG Cerebral Palsy. You do not improve or deteriorate with this condition. Why should people with conditions like these be subjected to reviews which will be a waste of time, require alot of form filling or appointments to keep. This will not make these peoples lives easier but more stressful This in itself makes disabled people different from those who are not disabled. All their lives they are going to be subjected constant reviews and assessment. This is not acceptable.</p> <p>3) Again this depends on the disability. These questions are a nonsense. The extra costs</p>

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	<p>will totally depend on the disability and how it affects each individual.</p> <p>5) Some health conditions should require an automatic entitlement. In this day and age it is not difficult to establish which conditions do not change. Those which fluctuate should be reviewed for re assessment as some conditions will improve over time and some will deteriorate. Some remain constant.</p> <p>7) By asking sensible questions of the individual and anyone involved in their care whether that is a health care professional of family members. You also need to bear in mind that some disabled people can be in denial over the level of care or help they may need as they fight to try and appear independent. This needs to be acknowledged.</p> <p>8) Aida and adaptions are irrelevant. Why should someone be refused help just because they are using an aid or adaption? The fact remains that they are in need of extra help and should receive it.</p> <p>9) The current forms are repetitive and ask ridiculous questions such as the distance someone can walk before feeling unwell. If they struggle to walk it should not be measured. A difficulty is a difficulty. How can you judge that if someone can walk a certain distance and another cant that one should get the help and another not. It does not take into account the fact that getting around remains problematic. Make the information clear, unambiguous and easy to understand.</p>
ONLINE516	<p>1) These problems range greatly and obviously depend on individual needs. Many buildings and streets are still not 'wheelchair friendly', not all lifts in buildings are large enough for special wheelchairs or for independent wheelchair users. There is also unfortunately still a lot of lack of respect for disabled people who are often stared at whilst out in public and can be left feeling very insecure and unsafe. A huge problem that disabled people face is the lack of availability of carer support. Many people with disabilities (children and adults) are cared for by their parents, the parents are often left with little or none respite and are left exhausted. With other children to take care of, or jobs to keep, carers are left with not enough time to assist the disabled person with other activities other than the day to day personal care and domestic duties, this leaves the disabled person with no options into social activities or leading more active, involved lives.</p> <p>2) I feel it is important that any applications for DLA/PIP continue to be fully checked and verified by a health professional. I believe that these checks are in place now and a health professional is involved, but I also know that it can be easy for applicants to exaggerate the truth and I have seen for myself people who receive benefits which I believe they should not have been awarded, I myself have a child with severe disabilities and find it very offensive and upsetting when people claim to be worse off than they are to receive cash benefits</p> <p>3) I am basing my response to this answer on my experience as a carer to my eldest child who is severely disabled. It costs extra getting around from place to place, although it is fantastic to see disabled access buses now, they are often busy and filled with prams and buggies and do not have a great turning space, so this means a taxi is an easier option, but again although he has taxi cards, the cost is still much higher than it would be on a bus. We have a motability vehicle, which because of the size of my son's wheelchair is very large and goes through a lot of fuel. My son enjoys swimming, but due to his disability can not join in with the same type of swimming lessons as his sister, instead the costs of having one to one swimming for him is more expensive. He has special dietary needs, and our shopping costs a lot as our son cannot have a lot of the foods that his sisters enjoy so we buy him foods from the "free from" ranges available which are always much more expensive. Our son is incontinent, so we still need to buy baby wipes and nappy sacks and always will need to. He wears leg splints for support only when in a standing position which requires a larger shoe size than his normal size, so he needs shoes in two sizes. Most wheelchairs/special buggies do not come with rain covers, so we have to pay a lot of money for the specific rain cover that fits the chair. These are just a small handful of some of the areas where there are extra costs to our son's day to day life there are many more</p> <p>4) I think that it is important that there is not a requirement that you have to receive one of these components to receive the other. They should all be assessed as individual components as everyone's needs are individual and if you have a rule which links them then you are risking some people losing out on a component of the award that they should be entitled to</p> <p>5) I think that whilst I can see the sense in this and it makes it a fair benefit, there are very unfair factors here. I think that all claims should be based on individual circumstances and that the doctor/specialist treating the claimant should be the one that is asked if the disability is likely to be longterm. Having to wait 6 months before claiming seems a long</p>

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	<p>time for some people who will know straight away that they are going to be disabled long term but left waiting half a year before they can claim. I have agreed with most of what I have read about the new benefit but i strongly disagree with this part</p> <p>9) The form is a long and difficult to fill in and often leaves you feeling low as you have to constantly go over the parts of your life that are difficult. I think it would be easier if the form was in more clear sections, and each question had a little information about what is being asked. I think that you have to remember that for most people with or without disabilities, no 2 days are the same so to ask about hours and minutes spent in each day at each question is automaticly leaving the person filling in the form in a difficult position. perhaps some information about what is being asked, and a good amount of space left for the person to put as much information as they can about this topic is more reasonable and easier for the person filling in and the person assessing the application.</p>
ONLINE517	<p>13) By advertising</p> <p>14) Full criteria list with a weighted points system</p> <p>15) Families &amp; Social Workers should be included in such arrangement,with the emphasis on the former.Features would be on/for those who know best bearing in mind the disability degree.</p> <p>16) Current funding by DLA,mobility,with an option for a one-off PIP contribution.But if this were to be so then DLA for the handicapped should stay.</p> <p>17) Why should there be a difference?</p> <p>18) Works now,why change?</p> <p>19) One suspects more red tape</p> <p>20) More sharing seems to be the right way to go but the appointed assessor will need a higher level of training</p> <p>21) Evenhandedness is vital,why should race or any other factor be treated differently?</p> <p>22) Yes,for some reason I cannot bring up Questions 1-12.Please will you correct this? My email is [REDACTED]</p> <p>Thank You</p> <p>Mr [REDACTED]</p>
ONLINE518	<p>1) Many "normal" people don't see the disabled as people, and as something worth while to give to society. Plus a lot of employers tend to employ those with easily recognisable disabilities, so those with brain injuries or mental health issues are less likely to get employment.</p> <p>4) DLA at the moment has three rates...Low- Medium-High. How is changing it to two rates going to be beneficial to someone who for instance has low rate in mobility but high rate in care. IE they can walk and carry certain things, but need help when going outside, to catch buses etc. IE They need a support worker with them.</p>
ONLINE519	<p>1) 1. People who have a shared ownership property under the SOLD model are at risk of losing their home if they take a low paid job because there is no mortgage element of working tax credit. Most of them moved into such a property to enable them to have the support they needed to live as independent a life as possible but if they work they will lose that support. It seems perverse that the only way they can own their own home is by remaining on benefits where the mortgage is paid through income support. Surely it would be better to extend the payment of mortgage interest to people with disabilities in work. This could also apply to people who acquire a disability and who are not capable of returning to the level of employment they were previously in - they can stay in their home with the mortgage paid if they are on benefits but not if they go back to a lower paid job.</p> <p>2. Transport is a big issue - not everyone can access public transport and there are times of the day and certain areas when and where it is not safe for vulnerable people to use it. If they can't drive this means they have to use taxis which are very expensive.</p> <p>3. Having the appropriate level of support is vital - it worries me that the emphasis is on those in greatest need - whilst they should of course be supported it is vital that those with lower level needs are also supported to prevent them becoming worse and needing more care in the long run. The current low-level DLA is vital in this respect.</p> <p>13) Those who are suffering from a severe mental health problem such as schizophrenia or who have dementia will not necessarily be aware of changes in their needs and will not be able to report any such changes.</p> <p>1) Transport - need access to suitable transport, not only that which is adapted for</p>

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	<p>wheelchairs, but in which those with other disabilities can feel and be safe. Even those who can travel on public transport during the day may not be safe doing so in the evening.</p> <p>Housing - the shared ownership scheme for people with learning disabilities (SOLD) is a very good idea but there are worries now that those who have a mortgage under such a scheme may be at risk of losing their home (and all the support that goes with it) if they are forced to take a low paid job due to changes in benefit rules. At the moment there is no mortgage element of working tax credit. It seems bizarre that those who can't work can be home owners but those people who are able to work are penalised.</p> <p>Meaningful activity - this should include voluntary and part-time work which is valued as much as full time employment. Many disabled people and those with mental health problems can make a contribution to society but could not cope physically, mentally or emotionally with full time work.</p> <p>Money - proposed cut backs in benefits could result in those who are most vulnerable becoming socially isolated. At the moment there are serious disincentives to getting even a small amount of work - no-one should be worse off if they are working than if they are on benefits (see comments above re housing and mortgage payments) Those who will never be able to work should not have to spend all their money covering their care needs alone.</p> <p>2) DLA should not be means tested. It should continue to have two elements for care and mobility. There are real concerns about the future for those who are currently on the low level of DLA - if the money is focussed in future on those who are most in need then those with lower needs will lose the little bit of support they currently get which enables them to have a reasonable quality of life. This could end up being more costly in the long run - prevention is always cheaper than cure.</p> <p>3) Costs for personal care  Extra heating  Equipment  Transport  Accessing opportunities for meaningful occupation - education, volunteering and leisure as well as paid work</p> <p>4) Very concerned about the loss of the lower rate of DLA - it is all very well targeting those most in need but people on the lower rate rely on it just as much and it makes a huge difference to their quality of life - losing it could affect, in particular, their mental well-being which could lead to more costs to the state in the long run</p> <p>5) Terminal conditions otherwise it does seem more sensible to look at the effect a person's disability or illness has on their needs - but this is what happens already with DLA</p> <p>6) Personal care delivered in a sensitive way that respects people's dignity  Food, warmth and good housing  The opportunity for meaningful activity that stimulates the person and enables them to have the best quality of life possible.</p> <p>7) Train the assessors  Ask questions that enable people to fully explain how they are affected  Ask other people who know the person (especially their carers) - particularly important with mental health problems when the person themselves will not always give a true picture</p> <p>8) Only if it is realistic. Just because someone is in a wheelchair or has a mobility vehicle, it doesn't mean that all their transport problems are solved. Similarly, home adaptations and equipment may help but it won't necessarily mean they don't need other help.  Regarding those that the person may be eligible for - often there are very long waiting lists so again this has to be realistic and take into account help that will be needed until such aids can be obtained.</p> <p>9) Claim forms always need to be clear and people have to know where to go to get help to fill them in</p>
ONLINE520	<p>2) Many Chronic conditions do not improve, but only worsen. It is hard enough to have the condition, the pain, the daily struggle without having to keep going back every couple of years to be 'assessed' all over again. Keep clause about chronic conditions in. There are not that many listed. Multiple sclerosis is one of the conditions, and life is a struggle, it is painful, debilitating and difficult. Please do not make life even more of a struggle.</p> <p>3) Housing. adaptations, HEATING COSTS. if you are under 65, do not qualify for income support, you struggle to pay heating.  Transport costs - rural areas, either no public transport or unsuitable vehicles. Taxis' are very expensive.  Medical costs. Prescriptions, - prepayment helps, but if you are struggling with other large</p>

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	<p>outgoings such as heating, even that is not a great deal of help.</p> <p>5) Those chronic diseases/impairments which are already automatic entitlement should stay as they are. ie MS it is a disease which has a disasterous affect on its' sufferers. in terms of pain, debilitation, everything which other people take for granted is more than an uphill struggle, it can compare to climbing a mountain, and that is just a visit to tesco. It is not fair or reasonable to expect people with these type of medical conditions to be assessed, and then re-assessed. what part of incurable, chronic and painful do you not get?</p> <p>having been assessed once, do you think that the medics got it wrong? they have suddenly found a cure behind the sofa? i could go on, but it will make no difference</p> <p>5) Yes, they should remain. The medical conditions which are currently automatic should stay. There is no cure, the conditions are not going to get better, if anything get worse - the physical aspect of dealing with the problems thrown up by the condition become more difficult.</p> <p>8) No, adaptations should not be taken into consideration. Sometimes. although an aid or adaption is there, it can only be used for a short period of time - as it is often the case that use of an adaption [such as crutches]may after only a short time cause pain to another portion of the body. Not all disabled people are fit enough to use different sets of muscles to replace another. So no, aids, and adaptations should not necessarily be taken into account.</p> <p>9) Use clear English, and don't make people feel that you are trying to trip them up with their answers. make the questions as simple as possible, such as when you ask a Q. can you prepare a meal for yourself, make it clear whether you mean 'can you get a frozen dinner and microwave it', or do you really mean, 'can you prepare the meal from scratch, can you mangle hot saucepans, do you need assistance with this or not'.</p> <p>10) Evidence from GP's, Specialist's, specialist nurses combined with the patient.</p> <p>16) Currently people have used their savings if they have any, maybe the local council might come up with some help to fund a bigger project, such as a bedroom, or bath/shower room. NHS manual and power wheelchairs are available [the latter with a long wait] Currently there is the option of giving up your mobility benefit for either a car or a p/wheelchair. The option of the car has a lot of pro's but also i believe a lot of strings, like mileage, and it can be a long time without when it comes to services or repairs.</p>
ONLINE521	<p>1) The extra costs involved, as severely disabled or severely mentally impaired adults especially, will always rely on escorts,carers or adapted vehicles and many will never be able to live independant lives</p> <p>2) The currents rates should not be downgraded also the automatic higher rates rules for the severely mentally impaired claimants should stay the same</p> <p>3) The cost of care providers,travel by taxis or specially adapted mini bus,In some cases the cost of replacement bedding and furniture and clothing ,mobility aids</p> <p>4) Claimants with lifetime awards ( many having needed to go though the tribunal sevice for theie award)should not have to partake in reassessment )There would be risk of their lifetime awards being downgraded and them needing to go to tribunals again.This places too much stress and burden on the carers of claimants who are unable to act for themselves.</p> <p>5) The benefits and rates of benefits already being received and already assessed as life time awards should not be affected by these reforms.</p> <p>This is important if the the claimant is an adult who has either multiple disabilities from birth (who's condition has no propect of getting better),or more especially if the original ongoing award was given due to the claimant having severe mental impairment,profound deafness,blind or other severe or congenital physical disabilities where improvement in their condition is unlikely to occur etc and whereby the adult relies on other family members to provide their lifelong care as they have no prospect at all of living an independant lifestyle.</p> <p>6) Look at the claimants on your database who already have lifetime awards of DLA</p> <p>9) Ensure that Social Workers are well trained in your procedures.As many severely metally impaired claimants will rely on their social workers to advise their carers to make claims on their behalf.</p> <p>10) Evidence from Gps and Social Workers</p> <p>11) The healthcare professional should also contact the claimants healthcare advocate or</p>

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	<p>social worker for a complete picture before the review.</p> <p>12) This should be a purely paper review for claimants with already lifetime awards with only a signature required stating no changes, either by the claimant or by a carer or social worker when the claimant is unable to act for themselves. There should be different reviews for various claimants, with the claimants in the most severe categories eg severely mentally impaired being classed as non reviewable claimants.</p> <p>13) It should be noted on your system when Claimants are unable to act for themselves due to mental incapacity and who have no prospects of ever being able to do so so that they are omitted from reviews. Claimants who are able enough and therefore not classed as vulnerable adults have a responsibility to inform of any changes in their condition</p> <p>?) As many severely disabled adults are in receipt of a number of benefits and payments, including local authority funding, independent living payments etc because they cannot live independently without a carer or care services, assessments for all benefits and payments received by this group of life time awarded claimants should be combined into one assessment at point of entry into the care/welfare system and information shared across all departments and agencies` ,</p> <p>?) Claimants with severe mental impairment will rely on carers/care providers or Social workers to make the claims on their behalf, therefore it is important that the advice is fully amalgamated into the care plans at the disabled person's point of entry into the welfare system.</p> <p>?) For a claimant to receive DIA or the new PIP their condition has been assessed as being severe enough to warrant the Benefit payment. This is the ultimate proof of disability and therefore this is important as a passporting tool. However information must be shared seamlessly across all departments and agencies.</p> <p>?) It has been my experience over the past ten years, as an unpaid supporting relative of a family of three disabled adults with quite complex needs, that the various departments involved in their care, have been quite disjointed in sharing information about claimants, leading to excessive form filling and multiple reviews for the different benefits. The different departments do not seem to share information. Information about a claimant, therefore, does seem to become lost in the system. Each disabled person should have a contactable case worker, who has access to a claimant's social worker or medical records. If that case worker leaves their post the information should then be passed on to the next contactable case worker within the DWP Team.</p> <p>?) You should look at whether the condition is congenital or severe with little prospect of improvement or may become more problematic into adult hood</p>
ONLINE522	<p>5) individuals who cannot claim in their own rights and have to rely on a parent or carer to apply for help and assistance, e.g people with severe learning disabilities, degenerative disease, severe brain disorders, should have a major right to automatic entitlement.</p> <p>9) use a tick sheet for definitive answers to direct questions, not paragraph answers.</p> <p>10) GP evidence, consultant reports, social workers, and check full history, i.e if a person was born with a genetic, or severe learning disability this person will NOT get better over a period of months/years, for example if a "normal person" had a hip replacement then they may get better and then become mobile and considered mobile and mentally able.</p> <p>12) people who have led a "normal life" and maybe had an accident and become disabled for a period of time, or a person who has suffered an injury and had an operation, their application for continued payments should be reviewed at minimum annually. e.g for a person in a car accident who has lost both legs will continue to have that disability for life, however a person falling from a set of three rung steps may have a dislodged disk and be in pain for several months and be off work, but an operation and physio will lead to a sustainable recovery. (12 month review max)</p> <p>16) adaptations such as wet rooms to the ground floor of a house, funded through a home loan or re-mortgage. funding from family and carers</p> <p>17) The disabled child's quality of life and their parent or carers quality of life. their stress and anxiety is large enough without money and support worries. children deserve a right to thrive and gain from maximum support.</p>
ONLINE523	<p>1) I have worked in social care for many years and feel that the barrier in my particular fields are lack of understanding by others, education and social stigma I work in Mental Ill Health. I feel that until the social climate changes with commonsense approaches rather than political correctness then persons with disabilities will always struggle. I also feel that any new systems implemented need to be clear and concise and well thought out. I make</p>

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	<p>this judgement on the recent implimentation of ESA which has led to massive problems for both persons claiming it and persons implementing it as their was a clear misunderstandign in the begining by how it worked with the wrong information given by staff. There is also massive problems with Direct Payments and how people can access it this again is extremely complex. The new benefit needs to be accessible and clear to everybody.</p> <p>The new benefit needs to enable the person to access and use the benefit in order to buy/impliment the help/support that is needed with the minimum of red tape and clear paths forward.</p> <p>3) Support - Transport In my particular profession it is support cost and transport. The cost of support needs to be accessed at the appropriate level and again easily accessible so that people can purchase the support they need by the person they choose, however this must not become as complex to administer as direct payments.</p> <p>4) No. I feel that only having two levels could compromise the level of support that is needed/accessed. What will happen when a person clearly needs help but does not fit specifically into one of your boxes? Will they recieve the higher amount? I also feel that the disabled person is not bothered as to what level they are awarded as long as they can access the amount needed to purchase care/support/transport. Regarding adminstering this benefit - will the expectation be that the disabled person will administer each component seperately? And account for this as again we are dealing with complex issues that the disabled person will not be able to manage. I am concerned that we are going to get into a scenario similiar to that of direct payments where in my experience people are not accessing the amount to pay for care as they cannot administer the paperwork. The cost of having someone to administer the paperwork/payrol often excedes the amount that was awarded or alternatively eats into the care budget.</p> <p>5) This is difficult as in some cases a care need is obviously needed ie sight/hearing impairment and so therfore yes it should be automatic however individual needs need to taken into account. This could impact on person that do not fit the exact criteria we must be careful that these people are not excluded and that individuals are treated as such and not put into specific boxes!</p> <p>6) You carnt it needs to be person centred with their care team and family members. Unless you are intent on imposing this via stat agencies how will you or can you make these decisions. If this is the case then how/who is going to pay for the extra resourses needed??</p> <p>7) I think a the whole picture of the person needs to be looked at and not just how many times a day a person needs support.</p> <p>8) No. This is not a practical assesment - if the person has no mobility but is able to access a car this does not mean that this can always be used or accessed. The person should be assessed on need and not on what is already available to them. However the need for adaptations needs to looked at and also the cost of these - adaptations have to be purchased and this should also be taken into account - can one off payments be made to purchase these??? As their is no other benifits/grants to access these.</p> <p>9) The one major issue that comes to mind is that the benefit is put in place for set amount of time and at the end of this time a full application has to be remade. Why when in cases this is a lifetime disability? Why not just award this for a lifetime or if a set time why can a declaration no be made by the person to confirm that they are the same? It is a complete waste of resources in many cases to have to complete a full application when the person's health or needs have not changed.</p> <p>10) Clear evidence needs to be sought but this needs to be somebody working closely with the disabled person ie a carer or support worker. I feel that asking a GP or consultant is ludicrous they are fine to confirm the illness but have no idea about how this impacts on a day to day basis. They have no knowledge about routines about what helps and what indures the person. They seldomly see the person and rarely see them within their own environment. The person when attending to see professionals have had days or weeks of notice and have geared them selfs up for this arranging transport, clothing etc. This is often treated as a outing by the disabled person and not a assessemnt of their needs. A assessment needs to be made over a long period of time I also feel that positives inder the process. If for instance a disabled person says that I go out for my lunch then it will be</p>

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	<p>deemed that they can manage to socialize go out alone and make appropriate transport arrangements. They do not taken into account that this may happen once a month with several support workers in attendance and a suitable vehicle that has been ordered several weeks in advance and that the person may only be able to go once every six months because of health issues. I realise that you can only work on the information given - I feel that the forms need to explain exactly in plain uncomplicated English was is been asked for.</p>
ONLINE524	<p>21) As far as I can see your impact will be the same across all aspects of equality.</p> <p>1) Barriers are not enough money to do what normal abled people can receive. Not enough security as we are always living with the threat that any money we rightly get can be taken away by the whim of the next government reform.</p> <p>Not being given the respect that disabled people deserve for the things that they do. The way we are portrayed these days leads people to categorise us a frauds and cheats and frightened of work. This simply is so undeserved for those genuine ones amongst us who have enough to contend with in our lives without being branded unfairly and this is a huge deterrent in our lives.Why? Because if we try to lead full and independent lives society then says why are they claiming benefit then? So we cant win.</p> <p>1) The worst are not having enough shops were you can enter easily, ie steps either outside or inside the shop. The new shops are ok but in the old town centres or market areas. I do not suffer barriers to obtain work as I had to retire though ill health as a teacher and was recognised that my industrial injury caused me not to be able to work so my pension was enhanced. I have now reached retirement age and receive state pension. Which means DLA has been very important for my financial security. However if this new PIP takes away my award unfairly then the lack of an adequate amount of money to live on will cause great emotional distress and huge insecurity and will stop me leading a full active and independent life as I wont be able to afford to do so.</p> <p>18) To my husband and I this has been one of the really good aspects of the DLA where we have used it to have motability. As a result of having DLA we have a better deal when paying the staywarm monthly payments and also for being seen quicker on call outs,breakdowns and/or repairs. These really need to be kept.</p> <p>19) The implications would be life changing in terms of what we could afford and whether for example we would be able to run acar which is very important to us to see our family who live a distance from us and also to get to the doctors easily or for hospital treatments which I spend my life doing! The Blue badge is so useful too. We would find it very difficult to keep ourselves wam too and for my condition it is vital to be comfortable and not cold. If each one had to be applied for individually then it would cost you much more in administration and yet more time for us spending on filling out forms and wondering and worrying if we would get them. We need security in our lives and we need life to be made easier for us not more difficult.</p> <p>Why should it suddenly not be possible to use the DLA or PIP as it will be then as a passport to other things? Surely you don't want to lose the good things from the award that run well and are seen to be a success?!</p> <p>2) I was awarded an Industrial injuries award for life long before I was granted an indefinite award for DLA. Once one award is for life the rest should follow.</p> <p>It would really help if incapacity was not taxed or state benefit if one is awarded DLA it would help us to live a better standard of living. Most of us who have lost our jobs as a result of our disability we have suddenly lost a huge amount of money. IF DLA and all other benefits were linked then when DLA or PIP was awarded this other benefit could happen(taken out of the Tax band) and that would help and also minimise bureaucracy.</p> <p>3) The main extra costs are:-  Buying extra equipment, like specialist beds for example  Paying for special diets.  Paying for extra help and support.  Paying for different types of clothes we might need.</p> <p>4) Much depends on the criteria for each level.</p> <p>If the criteria are designed to eliminate as many needful disabled people as possible then the two rates of component may mean that those who were paid on high level will suddenly find they are on low becuae the new PIP is designed to save money not help those most deserving.</p> <p>It may be that your high rate now is much more difficult to achieve in both instances and therefore instead of having two rates there should be a sliding scale much as Invalidity</p>

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	<p>benefit. Or that there should be three scales so that you are not moved from the highest to the lowest in one foul swoop but in smaller steps. This would be fairer.</p> <p>5) All claims should be based on the needs and circumstances of the individual applying. I spent nearly three weeks putting my last claim together and gathering all the medical evidence and this was the fourth time of receiving high for both. However this time I have been awarded an indefinite payment as my condition has worsened and has medically been proved by all my consultants that it will never improve. Having spent so much time effort and stress filling in the form and having medical evidence from consultants I do not see why those who are in this category of retired, high for mobility and care and indefinite awards should have to be reassessed. We have proved our need. In front of medical assessors ie our consultants and should not need to go to any other medial examination where their criteria will be to eliminate as many people as possible and not help them. Why am I so cynical of this award? You have admitted yourself that too many people are receiving it and you need to reduce numbers. This does not bode well for those who have already proved their entitlement and should not have to be required to go through the whole stressful process again.</p> <p>6) Take notice of what the consultant is treating the disabled person for and not what a medical examination of a few minutes can reveal. The treatment a claimant is receiving over a long period is far more revealing and fairer than a medical where the criteria a loaded against the claimant, the person being interrogated is under stress and does not give a good account of themselves under those circumstances or the criteria are such that most people will find themselves without help.</p> <p>Activities essential for everyday life of getting up, washed, dressed, fed, ability to make a meal, taking medication, going out, being able to move around the house, getting in and out of a chair, going to bed. All the ones that are questions found out about more than adequately and asked many times in the forms now.</p> <p>7) A simple form being sent out asking if our condition has changed and if it hasn't leave well alone and dont make people have to repeat the whole process. This will save a huge amount of money.</p> <p>8) The whole point of aids and adaptations should be to make the claimants life easier, but not be used as a means of not giving them any money as a result. Having an adaption does not take away the pain or the difficulty of carrying out normal life requirements and the inconvenience of having the disability. How are you going to account for that?</p> <p>9) To make the claim form easier do not ask the same question five different ways and expect it to be filled in so fully each time. If you have that information once be satisfied and not ask for it over and over again.</p> <p>Make it clear who can qualify and what the criteria are for being awarded it. Ie nobody should be awarded it unless they have medical evidence for each thing they are claiming for then you would not get benefit fraud. At the moment we are now suffering for those who have claimed fraudulently and it is not fair that we should all be thought of as such.</p> <p>10) As I have already said the people most able, and best placed to give support for your claim are your consultants. The fact that you are attending these people and for what and when should be good enough, together with any medical repots you have from them. Not a one off medical at a social services office unrelated to anything other than you need it to get awarded the claim. This medical can be so loaded that many will lose their claim unfairly.</p> <p>I can understand why you feel that our own family Dr is not necessarily the one which should be given the final supporting evidence, as they may, as you say, feel obliged to support you. However they should certainly be one of the package of medical evidence you have to supply. They are, after all, always the ones that have to decide to refer you to a consultant in the first place. Although in my experience my Dr would never feel obliged to support you if you didn't deserve it, no matter how well you knew him.</p> <p>11) If you have provided all the medical evidence from a consultant and this has been shown to be happening over a long period of time there should be no need to have a healthcare professional. You are trying to save money yet you will be Spending huge amounts of money on every claimant having expensive healthcare professionals interview you.</p> <p>IT IS INAPPROPRIATE TO REQUIRE A FACE TO FACE MEETING IF YOU HAVE ALL YOUR MEDICAL EVIDENCE PRESENTED WITH THE CLAIM. ONLY IF THERE IS NOT ENOUGH MEDICAL EVIDENCE GIVEN SHOULD A HEALTHCARE PROFESSIONAL BE USED</p>

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	<p>12) The consultants or doctors report should give a good idea of whether the condition will cause deterioration over time or if improvement is possible.</p> <p>1. If the evidence is no improvement then don't waste time or money on reviews asking people to repeat the same information. This causes huge stress for someone who is already suffering from a disability. This is what wastes vast amount of departmental money too.</p> <p>2. Yes different types of review. If the impairment is such that people can recover ask for a five year review and the individual made responsible to report improvement if that takes place before then.</p> <p>The most important thing a disabled person needs is financial security in their life not the fear that it is going to be taken away from them at any moment.</p> <p>Your aim or criteria is to get more disabled people working. If this is the case review those more who are of working age, but what is the point of doing so for a person who has retired and already assessed as high for both for life. We have had to go to such lengths to prove that, so do you doubt your own assessment? It was so difficult to get that it shouldn't be doubted.</p> <p>13) Claimants need to be seen as reporting to their doctor on a regular basis about their condition. If a doctor hasn't seen them at all about it for a long time this is a fairly good indication that the condition is not causing much difficulty. So unless claimants are still under medical care, or regular attention then they lose their benefit or it is reduced. That way those that say they are disabled but never see a doctor would soon be found out. Or it would soon show up that the person's condition had improved.</p> <p>14) I use my mobility part of my claim for motability and this is my second car and hope to have a third when the time comes. So it was very useful to have that option and advice. When benefit is received a pack should be sent out stating what help is available and what price it would cost for care. It may be useful to send new claimants on a care course. Although funding this may cause more money to be spent and you are trying to save it! People should not be made to feel that unless they have it they will not get the care component. The beauty of the way the claim is paid is that if a person wants it to help look after their garden as they can't bend down or do gardening activities then they can. Another may use it to help clean their windows as they can't stand on a ladder. It is the freedom to use the benefit as the disabled person sees fit that makes them feel independent and and this is a good thing to make them feel that they are leading a more normal life. if people feel they are being forced to spend their money on an aspect that say their husband/wife/ partner can do for them then you are taking away choice and it then becomes a very nanny state with no freedom of decision making.</p> <p>15) 'Requirement' and 'encouragement' used in this way sounds a bit like a polite way of forcing people to do what they don't want to do. Certainly courses should be made available and as I have said before an induction course for the new claimants may be a good idea as to what they can access and that could be part of the claim package. Educating people to know how they can be helped is a good thing if it is done in the right way.</p> <p>16) I use my money to fund aids and adaptations from places like Keep Able where the VAT is taken off if you produce evidence that you meet the disabled criteria.</p> <p>17) If the child is very disabled then a package for life-long care and adaptations to the home need to be considered as well as educational needs.</p> <p>Once again though the carer needs to know that once the benefit has been awarded that it is not going to be taken away and that they are not spending all their time filling out forms to the detriment of looking after the child.</p> <p>?) This new proposal has caused me huge anxiety and countless other genuine claimants. Ever since 2001 I have been applying for and awarded DLA for the last four times at High for both and on my most recent one when the medical evidence was so overwhelming I was given an indefinite award. I am at retirement age and receive state benefit. If you have already assessed me as being eligible for this entitlement and have done it so diligently and I have supplied such detailed evidence it seems grossly unfair that I should be subjected to the stress and worry of yet more form filling and interrogation.</p> <p>There should be a category of people who within the new reforms don't have to apply again and don't have to complete the new PIP forms. Your main aim is to save money surely this would go a long way to saving it rather than making everyone, even those who you have assessed as beyond doubt, fill in forms. Instead my suggestion is that those you are satisfied with and meet the criteria I have suggested, you just send a form to saying the</p>

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	benefit will continue to be paid under the new title of PIP and leave it at that. You will save countless millions and much heartache.
ONLINE525	<p>1) Very dependent on the impairment. The barriers and problems are as diverse as disabled people themselves. Although there is now protection in law from discrimination, attitudes remain a huge problem. Many non-disabled people do not value disabled people, see them as a drain on society etc, and there are widespread incidents of abuse.</p> <p>2) The mobility component must be kept for those in residential care, not removed as planned. The current proposal to remove this is both discriminatory and based on complete ignorance of the facts</p> <p>3) Extra heating if mobility impaired, clothing as need thicker and or adapted garments that need constant washing, personal care support, specialist aids and equipment eg hoists, wheelchairs etc, continence supplies, transport as public transport often inaccessible, and/or walking not possible, adapted environments/buildings</p> <p>4) It may be simpler to have 2 rates but the danger is that those who enjoyed the lower rate will be excluded. Flexibility is essential given the diversity of needs</p> <p>5) yes there should be an automatic entitlement for some conditions/impairments, as for example dialysis ALWAYS has a significant impact on an individual, and there MUST be provision for those whose conditions vary.</p> <p>6) manage personal care and health needs, eat and drink and be housed appropriately are baseline essentials, alongside interaction with others. However, just as Eligibility Criteria to Social Care are now restricted to substantial and in some cases only critical needs, thus excluding many very needy people, this assessment will do the same unless carefully and fairly managed. If priority is given to those with the greatest needs many will fall through the net and lead to the most appalling injustice and scandal in a rich society such as ours.</p> <p>8) Use common sense based on cost. All continence aids should be free, but people should not be expected to use these aids just because there is no money to get someone to help them to the toilet when they need to go - this is a real negation of human rights.</p> <p>9) make sure the form is available in a range of formats, use Plain English, and keep away from jargon. Need a checklist to indicate eligibility</p> <p>10) GP, family member, employer, hospital consultant school teacher etc. It will inevitably vary according to the impairment and degree of impairment</p> <p>11) Access to the venue can be a real problem, both in terms of the venue itself and getting there. Will also depend on the healthcare professional's expertise and training. Not always a health issue - remember the Social Model</p> <p>12) Not sure yes there MUST be different types of review. NB the failure rate of recent reviews of INCAPACITY BENEFIT. LEARN FROM THIS</p> <p>13) BY REWARDING THEM, NOT PENALISING THEM</p> <p>16) Very varied and dependent on post codes, eligibility , financial status etc</p> <p>17) of course disabled childrens' needs change as they approach adulthood, and they fall out of the statutory support available to children. yes there needs to be careful consideration of needs v age. E</p>
ONLINE526	<p>1) Job security and disability discrimination</p> <p>If you take for example a 'good' employer - the civil service where you are three times more likely to be discriminated against if you have a disability than those that don't (task force set up to look at this issue to report in 2011) then the question that has to be asked is if the aim of DLA reform is move more people with disabilities in to work to become less dependent on the state then what protection will those with disabilities have at work?</p> <p>The Equality Act 2010 does provide a legal framework to challenge discrimination, however it requires the discriminated to challenge their employer. Not a simple, trouble free process. It does not cover an employee in full if they take disability related sick absences in the fact that the employer could sack the individual on capability grounds, the employee could as well lose pay as a result of sick absences relating to disability.</p> <p>DLA reform therefore needs to reflect on how those with disabilities will be treated in employment and consider additional legislation and/or providing employers with financial incentives (perhaps tax breaks - National Insurance) to employ those with disabilities.</p>

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	<p>As a disclaimer, I recognise that not all disabilities attract a substantial increase in sick leave.</p>
ONLINE527	<p>3) Paying a carer to help with everything connected with one's disability, extra heating as the person is sitting a lot more than able bodied person, clothing, equipment, transport, medicine, and Help during the night...</p> <p>4) It is good to have two rates per component. It will be easier for DWP to decide what level of care one requires and hopefully it will be a fairer system. The more disabled will have appropriate benefits according to their disability do not see disadvantages in the above system</p> <p>5) NOT all conditions should mean automatic entitlement to benefits. The claimants should fall into categories depending on the seriousness of their condition and circumstances. Learning Disability Group should be differentiated from any other group. The elderly who have savings and properties should contribute towards their care and receive benefits only in special circumstances. All claimants should be individually assessed according to their needs and circumstances.</p> <p>Surely it is not fair, if people who are temporarily unable to walk should receive disability/mobility allowance.</p> <p>6) It should be no 1 responsibility of the state to ensure meaningful life to those who are at least able to help themselves, people who can only live a full and active life if they get help from paid personal assistants/support workers who would organise and carry out quality care and activities. There should be a balance and an acceptable ratio</p> <p>in necessary activities and leisure activities, just like any other "normal" citizen require.</p>
ONLINE528	<p>1) Because of their disability they are unable to do the basics of everyday things that able bodied people are able to do, such as being fully continent and able to go to the toilet unaided, being able to change their clothes or bedding when accidents occur. Unable to get washed or dressed unaided, unable to change clothes unaided. Unable to shop, cook or clean in a household unaided or safely. unable to reach everyday objects because of being unable to stand or walk. Unable to access buildings. unable to use public transport without help. unable to manage finances without help. unable to take part in activities both social and sporting without assistance. unable to live independently because they need to have someone on call 24 hours a day because of incontinence, changing, dressing, toileting, access barriers, transport, parking etc.</p> <p>2) if a person is born with a severe disability that will not improve or change significantly during their life time they should not have to be reassessed as nothing is going to change if anything things get worse as they get older, people are less inclined or likely to want to help or care for larger older people whereas younger children are much easier to place and care for.</p> <p>3) it is not only the disabled person that faces these extra costs, the families have to pay for most things from their own incomes most of the time without any outside help or assistance. Housing and housing adaptations, accessible bathrooms and toilets, the need to have downstairs bedrooms and space for extra equipment and wheelchairs. Extra heating costs extra gas, electric costs for personal care washing and clothes, bedding washing. The need for extra bedding, clothing continence devices, pads, protective gloves, aprons, creams, prescriptions. Time is a huge factor, families unable to lead their own lives because of a disabled member needing care. Additional travel costs because of numerous hospital and doctors appointments, the need to have a very large car because of the need to transport wheelchairs and the difficulties of getting in and out of cars.</p> <p>5) yes some conditions should mean automatic entitlement. But during the initial assessment the severity of the individual's condition should be taken into account. There are a lot of individuals with cerebral palsy with a very wide degree of difference in disability. If an individual is totally dependant on a wheelchair, unable to stand or walk (this being a permanent state that can not improve) they should automatically be entitled to benefits</p> <p>6) I person may be able to interact with others and get around, but some can only do this with the support of others. i.e getting them washed and dress, escorting them to where ever, being on call to help them manage their personal care and treatment needs. Many individuals may look capable or appear to be managing independently but there is a lot of</p>

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	<p>support and intervention that is not always apparent to outsiders, it is imperative that who ever asses the individuals take into account the enourmous amount of care and preparation/ support back up that is provided that is not acknowledged or seen.</p>
<p>ONLINE529</p>	<p>1) Lack of access to areas. it is assumed all disabled are in a wheelchair or that people are fully fit. Lack of amenity for disabled walking.</p> <p>Lack of suitable seating for example in conference I attended.</p> <p>Why are disabled toilets often locked,it is difficult to get a RADAr key for them unless you are fully disabled. One of my main problems before my illness became worse was getting up/down off toilets but I often had indidgnity of getting stuck on an ordinary toilet because I had no key for disabled.</p> <p>3) Buying things to make their lives more independent,such as mobile step which means I can visit my son as the step there is too high for me to manage.but even hen the family have to assist me.Other equipment which means I do not have to ask for help so mch .We paid for a stairlift as my illness detiorated rapidly and there is 2 year waiing list for one. It helped towards changing our car to a automatic,so I can go to church independenly weather permitting. Pay for petrol,as I often have to be taken places,can not manage public transport. Pay for people to take them places Adaptations in the home. Special clothes,footwear. Special foods. Extra cost of insurance if you take a holiday</p> <p>5) I think some illnesses still should have an automatic qualification,especially those that incur extra expenses as many do.Also it should be recognised that illness mean people can have good days and bad days. While many things are available to make life easier most people have to buy them. also getting around is so expensive and public transport is inaccessible for lare numbers of disabled people.</p> <p>6) Hygiene,communication,being as independent as possible.Seeing friends and family,hobbies,transport to do many of these. All of these cost money and cost more if you are disabled in any way.</p> <p>7) By asking for a day in the life of a person on a bad day</p> <p>8) As people often have to buy these aids themselves and replace them,then money should be given to help buy aids.I worked as a nurse for many years pre my illness,I know hw difficult it is to get aids then only most basic is given the rest has to be bought. While wheelchairs are supplied after a wait,they are very heavy ,cumbersome if you want something lighter you have o buy yourself for example.</p> <p>9) make it more of a tick box with room for additional comments.It is easy to forget to put things down on present ones</p> <p>10) I would say person caring for them,often when people go to G.p. or health professional they do not tell them their true problems.How do they know how they manage at home I now my G.p has no idea and in my experience many do not. There re always exceptions. You could get occupational therapists to visit homes but with a shortage of these that is not practical. A list of how they complete certain tasks what aids they have ,difficulties they encounter doing them.</p> <p>11) People will find it hard to speak to total strangers giving intimate details of their life.</p> <p>it could be a very good day for them which could give totally false picture.</p> <p>On pls side it allows the real problems to be seen as sometimes fling out a form you might say you can do something but it does not say how difficult this is or how long it can take o do a simple task.</p>
<p>ONLINE530</p>	<p>1) For me as a carer living in a rural community services are not near and I rely on the DLA to make sure that the extra cost of transport and reaching things to make life better for the cared for is essential. This extra money I use in many vaied ways that if it were to be more focused and details it would be difficult, if not impossible, to claim. As it stands at present it fulfills all aspects to care for the disababled that I currently care for, and I need not apply</p>

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	<p>for any extra help and would be I think for many other too counter productive to fundamentally change this except by possible reassessment taking in features of where a person lives which has a negative impact that can only be addressed by extra income to cope with.</p> <p>3) Transport. In an area that has no public transport available close enough to access is one of my main concerns, high costs of fuel and specialized clothing and footwear.</p> <p>4) Having two rates does not reflect differnt problems experienced by individuals when thinking about the effects of dissability. People who are catered for in relation to accomodation, transport and support from social services do not have the same needs as someone isolated and who with monetary support is able to organise their lifes to a level that they are happy with, and do not want to increase the burden on the state further which would happen if the whole of life was not used in an assesment of needs and would at the end of the day be more cost effective than ridged rules.</p> <p>5) Althopugh some conditions are long term the impact on peoples lives depends to agreater extent on their circumstances, where they live and what if any family and support they already receive and also their own personal abilbity to cope. The mental impact of being independant should not be a barrier to being awarded benefit just because they seem to be coping, and others don't, this leads to greater dependance not less on the state from fear of poverty.</p>
ONLINE531	<p>1) 1. Lack of Money.  2. Lack of Confidence.  3. Lack of public amenities eg, disabled toilets etc.  4. Ignorance of the general public.  5. If you have been disabled along time and you have been on a limited income, you haven't had any spare money to have basic things like having your hair done, or having essential clothing for the activity, such as going to the gym etc.  6. Lack of time due to the fact, that doctor's are not very logical when it comes sheduling tests for patients. Instead of having both blood tests and xray's together, they will make a person go up twice. Not only that, outpatient departments are not open at weekend, which means that a disabled person would either have to use up all their holidays on hospital appointments or run the gauntlet of having an employer lose patience with them, thus losing their job.  7. If an employer had the choice of an abled bodied person and disabled person who has problems, they would choose the abled bodied person who just needs a little extra training.</p> <p>7. Lack of public transport/social transport for disabled people who cannot walk to the bus. The scooters that are not designed for public roads, and are very dangerous for the disabled person.</p> <p>8. Chronic pain and fatigue.</p> <p>9. Embarassing treatments or conditions. eg incontinence, or prescriptions that lead to you having to go to the bathroom and having accidents.</p> <p>10. Crime - abled bodied people fear being mugged or attacked, so imagine what it is like for someone who is disabled. The Police presence will only get worse with the cuts, and even when you see the Police, they are only interested in crime that creates more money such as Car Crime. In reality now, if someone phones the police if they are attacked they are likely to wait hours before they get seen to.</p>
ONLINE532	<p>13) Having a Consultant involved in the care of the person able to alert DWP about any significant improvement in circumstances. It cant be that hard to have an alert system linked from Health Care Computers to DWP</p> <p>1) Wehave adopted 3 children with complex needs. Each of them have very different needs and each present very differently. Participating in everyday life has always presented challenges. They are unable to gain from everyday toys without adaptations both to the toy and to the method of play, they have been unable to use mainstream baby equipment again without adaptation to both equipment and its use. Even cultery has had to be adapted. All of these things cost several times more than those suitable for a child witout their challenges. The DLA has always gone towards enhancing their quality of life. As they have grown up, our eldest son now approaching 21 their needs have never</p>

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	<p>diminished. They all still require 24 our a day care. Their needs to access life in general have indeed extended as time has gone by. It is no longer possible to adapt mainstream equipment they need specialist provision. This is often not available from free providers it has to be discovered and then funded. Our time as their carers is totally absorbed in meeting their every need and trying to give them the best quality of life we can. Much of that time though can be taken in fighting with beurocracy to get the support equipment and services to which they are entitled.</p> <p>Actually accessing the society they live in is only possible with total commitment from ourselves. So those who do not have a committed supportive family/friend circle would not be able to achieve intergration.</p> <p>2) Disability Living allowance GThat is awarded to people who have a life long or deteriorating condition should continue to be awarded for life. If someone has a disability that is never going to go away or is degenerative then filling in those forms just makes yet another stress, another rubbing in of salt in the wound.</p> <p>Yes if the condition is likely to be outgrown or majorly overcome it should be reviewed of course. But my son is not going to outgrow Down Syndrome with Congenital Heart Defect and Chronic Lung disease. Nor is my daughter going to ourgrow Cornelia De lange Syndrome with Intractible Epilepsy or our younger daughrer Leighs Encephalopathy. All of them will die from their disease or complications of.</p> <p>14) Many support groups for many conditions will have a forum that can offer advice to claimants.</p> <p>For Children directing them to <a href="http://www.specialkidsintheuk.org">www.specialkidsintheuk.org</a> will ensure they get the best possible advice from parents who have been there before. A list of support groups and websites that can help enclosed with the form would be very useful.</p> <p>The front page of the pack should have in bold print a statement advising the claimant to seek advice on filling in the form.</p> <p>3) As a family the main extra expenses we face are transport.</p> <p>We have 5 children 4 of whom have complex needs, we have as many as 20 appointments a week often meaning we have to go i opposite directions Dad with one child and Mum with another. The girls both travel in wheelchairs so we have a large WAV this drinks fuel. We have two other vehicles, a car we use whenever we dont have either of the girls with us and a 4WD so that we can get out in poor weather for medicines appointments and food, we live in a rural area and have been cut off in the snow the last two years, without the 4wd we would have been putting the girls in danger of running out of AEDs. Having the three vehicles means we have a back up if one is off the road for any reason.</p> <p>The next expense would be the utilities. We use an awful lot of hot water. Bathing the girls morning and night is an essential, [REDACTED] has a wet room and mostly showers but still this take a lot longer than normal and uses a lot of water.</p> <p>We have two oxygen concetrators, two feed pumps, two suction machines. Monitors and a through floor lift and hoists. All use electric.</p> <p>Inthe winter we have a large house to heat. [REDACTED] suffers badly in the cold and [REDACTED] does not cope too well either. so the house needs to be kept at a warmer level that if they were not here.</p> <p>Telephones we make and recieve phone calls to professionals frequently. We each need a mobile to be able to reach each other in an emergency and to be reached by professionals whenever necessary. A lot of communication is done by email too and a lot of research into resolutions to problems is done by internet search so access to the internet at home and when out is essential. I therefore have an iPhone to enable me to easily receive email on the go.</p> <p>Specialist equipment and recreational items are massiveley more expensive than mainstream equivelants. The switch toy my daughter had for Christmas was £14.99 for its mainstream equivelant, the switch operated version she needed was £79 so multiply the cost of toys for an average 7 year old by 5 to get an idea of the cost of equivelant for a child with a disability.</p> <p>Eneabling [REDACTED] to go swimming means finding a pool that will allow us to have Oxygen on the pool side, we need two carers in the water and one on the pool side...Social Services will maybe if we are lucky pay for one carer, we jhave to fund the other and one of us. The same with [REDACTED] and [REDACTED] so a trip to the swimming pool can cost us £50 on top of the usual admission fees. Then their is the specialist clothing. Swim nappy costumes for the</p>

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	<p>girls were \$45 each....instead of the £12 maximum I have ever paid for my other daughter. almost 4 times the cost.</p> <p>█████ is now about to leave his specialist college. He has no prospect of independence. his needs are such that he still needs constant one on one care. So with the idea that no one will be better off out of work he is destined to always be the poorest of the poor isnt he? There is nothing that is going to enable █████ to be an equal amongst his peers. Enabling him to make the most of his life is a different matter. Life Long Learning is what he needs. Funding to continue at the SENSE College that has enabled him to maximise his independence skills. Given him the confidence to be himself in the community fully supported and participating at his level.</p> <p>Unfortunately the personal budget he is offered will not give him anything like that and he will be forced into total dependence again.</p> <p>This is the future for █████ too. Not enough funding into disability services, the transitions team that has been so supportive of the post 16 children in Lincolnshire will no longer be funded so she will be left at the mercy of the totally inadequate adult services. We will be expected to continue to meet their needs despite losing all the funding that goes with a child...Child benefit, Child Tax credits etc.</p> <p>We also have another fear of loss of income if Our eldest home grown child needs to go to a residential school for the blind for 6th form. if he loses his DLA and Mobility allowance we will be unable to fund all the extra needs he has and the cost of visiting him will be prohibitive.</p> <p>Clothes are an extra expense, █████ is the height of an 8 year old but with the body development of a teenager, her clothes all need adapting or buying from specialists. They all wear their clothes out much more quickly than the others and incontinence means that stains cause them to be thrown out more frequently. The washing machine also never stops. Bedding takes a high maintenance cost both in washing and replacement.</p> <p>We have needed to buy Wheelchairs, █████ bed, medical equipment like Oximeters, spares for other things all extraordinary expenses.</p> <p>█████ has Coeliac Disease, although some foods are available on prescription much of the cake and biscuit things arent and are very expensive, We also have a daughter who is allergic to milk and again the cost of dairy free options is higher.</p> <p>15) I dont believe making it a requirement is a good thing. Making it clear that there is help available easily is better. Giving a list of help services is probably the best.</p> <p>Also making Social Workers and health Care Workers more aware of the availability of the allowance so that they offer their help in applying would be useful.</p> <p>16) I firmly believe that aids and adaptations for Disabled people should be funded centrally not locally. Making this a part of the DLA has always been my dream.</p> <p>A local assessment of need forwarded to the DLA Centre for them to fund a one of payment for the item. that best meets need rather than what the local agency wants to spend out of their budget.</p> <p>A local assessment of need by an OT/Phyio/speech therapist who knows the person and knows their needs will assure that it is a needs led outcome based assessment and that the need is then met appropriately.</p> <p>This should be an ongoing situation. Needs change in some people they change regularly and need reassessment and resupply. As in the need for my daughters Wheelchair.</p> <p>By Keeping this funding in central government there will be no difference in needs met in Lincolnshire Gloucester or the Isle of Wight. Everyone will have a needs led assessment and those needs will then be met!</p> <p>4) This will depend upon the quality of assessment process. If the assessor is impartial...not bent on cutting out claimants then yes it can work. Looking at the situation honestly taking time to understand and really see the difficulties. Not assuming that if a person can self propel then they are as able as a person with no mobility issues.</p> <p>Looking at what extra needs they have to a person without extra needs, not trying to minimise difficulties because they have no understanding of them.</p> <p>KNOWING that a person with Autism may be ok whilst totally supported by a parent but may be totally unable to function at even basic level when in an unfamiliar noisy environment.</p> <p>Making a positive contribution to society is not necessarily about earning a wage. Our youngest daughter is terminally ill,, totally dependant, needs a ventilator to breathe at night but ask anyone who knows her if she makes a positive contribution to their lives and they will assure you she does.</p> <p>Ensuring that people can continue to make a difference at their own level will not mean that</p>

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	<p>they are out earning a wage necessarily but will mean they can make that positive contribution. It is going to mean that money has to be spent supporting them but this is far more necessary than MPs Expenses and Bankers Bonuses. and will probably be cheaper than those two combined.</p> <p>5) Children grow up to become adults. Children with Complex needs who grow up to become Adults with Complex needs are different to adults who become disabled and people who are disabled due to age related conditions. The difference should be between those two groups not just children. Families who are devoting their lives to ensuring the best quality of life for their children need to be able to do that without slumming into poverty. And once their children reach 18 it should be accepted that the same level of care is needed. A dependent 17 year old is no more needy than a dependant 19 year old so why does funding stop? Enabling the families to function as a family by providing the funding to meet the need is paramount. Children who are in hospital for a long period need more care. The expenses on the family are huge. Traveling, eating out, providing stimulating play, splitting the family in two to meet the needs of the child in hospital as well as the children at home. Hospitals do not take over the care that families give when a child is ill. They may be doing the extra care needed due to the reason for hospital admission but often the work load on the parents is trebled along with huge doses of worry fear anxiety and stress. DLA should not be stopped in this time!</p> <p>6) Think about what activities of your day you would be happy to set aside. Not that you think you would grumble about but have to cope but in reality would not want to put aside. Those you would happily not be able to do. Personal Care hopefully everyone would feel is essential. Preparation of meals, feeding, then clearing away and leaving the house respectable. Getting dressed, undressed, clothes washed and ironed and put away. Choices in what to wear. Hair cuts and styles, Hair being kept respectable throughout a working day. Being able to talk to friends, being able to go out the house, Visit the shops, choose your food. Read a book. Do something you enjoy. Turn the telly over, Be able to choose a video and put it on to play. Turn the telly up or down. Move from one room to another. Scratch an itch. Be able to go to Church. Join a prayer group. Have Bible Study with a friend. Go out for a walk down the road. Go and visit family who live further away. Go to college/school/work Be safe have someone to watch you so you dont get into danger. Someone able to see when you are unwell, to get your medicine decide if you need the doctor. Someone to organise your appointments. open your post, read it to you or be able to deal with it for you. Someone able to organise your care for tomorrow, ensure that if your carer is ill someone else will come. Enable you to be who you want to be. A Full and Active life...those are just the essentials of being. How about someone to help you go watch a football match. Organise a Holiday. Take you swimming. Horse Riding. To the Library. Down the Pub for a drink. Enabling mobility means buying that vehicle your wheelchair will fit in. Ensuring you have the Wheelchair that meets your needs. this is often very different in reality to the wheelchair the WheelChair Services will provide for you. ██████ had a chair from WCS that lasted three weeks before the frame started to buckle and the tires wore out. We used his Mobility allowance to buy him a chair he could go out in daily and that lasted. kept him comfortable and really met his needs. ██████ Wheelchair was condemned by wheelchiar services and then they decided that because the needs it was meeting were more than just mobility needs, she has epilepsy and feeding issues and needed a chair she could travel in, it took 5 years before WCS and Continuing care could sort themselves out to purchase her something suitable, in that time we spent a small fortune on temporary measures, always anticipating they would sort something soon. ██████ is now needing a total review of her wheelchair because the current chair is</p>

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	<p>impeding her breathing she cant use her ventolator in it and it is giving her pressure sores...we have been waiting since November and have purchased a second hand chair that lies flat to enable her to go out when she needs her ventolator. It isnt ideal but it keeps her breathing while we wait. All costing money...this was £800 second hand!</p> <p>6) This system seems to work fine</p> <p>7) Surely that is obvious, more forms would be needed which would make more work for disabled people, their carers and the service providers.</p> <p>8) Theassessment should only take account of aids and adaptations that actually remove the disabiliity. COnsider if you would feel totally normal if your needed that aid. A wheelchair that allows a person to manouvre themselves does not make them able bodied. How do they obtain that chair, how do they transfer in and out of it, how able are they to use public transport, how do they fund the wheelchair adapted vehicle they need to get around and fund the extra cost of fuel to drive it or the carer to drive them in it? An aid to enable a person to function better does not remove the underlying disability. Maybe spend a week in a wheelchair with your hands tied behind your back and your voice box paralysed to see if your think the wheelchair makes you able bodied???</p> <p>10) Consultants involved in the health care. People who do the caring. People who know the client well but are of good standing. Minister, college staff, Nurses etc.</p> <p>11) The Health Care Professional will not know the person and therefore some situations this can cause a huge level of distress and fear in a disabled person. Sometimes a person can present very differently in a short interview than when you are dealing with a days events. Asking questions that have a yes no response can be very misleading in a person with limited understanding. This happened when the DWP came to talk to █████ about handling his own finances. Can you look after money █████? Yes. Can you manage at the shops █████? Yes Can you buy your own food? Yes At this point I asked to speak to the DWP rep outside the room. I told him to ask █████ if he enjoyed his holiday to the moon. Did you enjoy your holiday to the moon █████? Yes thank you. At that point the rep looked at me smiled and said point taken. All is not always as it seems in an interview. I had an assessment with a doctor in my own home and it worked very well but then I do not have a learning disability and the effects of my own degenerative disease were obvious. to The very tuned in Dr who came. The individualbeing assessed should always be allowed to have a carer who knows them well with them. Any learning disability must be thoroughly understood.</p> <p>12) Therearesome obvious situations when review is not necessary. Someone qualifying for highest level of funding who has a degenerative condition is not goig to get better. Some situations are also obvious syndromes and diseases/conditions that are not going to improve are going to cause more difficulties with age. Terminal illness Other situations that could improve should of course be reviewed. Children who have long term conditions should not be forced to review within 3 years as this causes severe difficulties with motability. We had the farcecal situation when █████ was younger when he was diagnosed with chronic progressive lung disease on top of his Down Syndrom, Heart Conditiona and Hip problems we were given an 18 month review...he so obviously was not going to get any better it was a waste of money for the DWP and an unnecessary stress on us.</p>
ONLINE533	<p>1) Awareness of our needs is the biggest barrier. Access to public buildings and even government buildings is still very restricted to anyone with mobility problems. This even extends to pathways that do not have dropped tactile kerbs at most junctions.</p> <p>2) Personally DLA wrks perfectly for me. For over 20 years I have used a motability car, without which my wife (who is totaly blind) and myself (with severe medical problems) would be housebound. Personal Care allowance allows us both to seek help as independant persons without the constant stress of re-evaluation of our conditions.</p> <p>5) There are obvious conditions that are transient and the government always seem to bring these up as examples. There are others where the condition is obvious and permanent. My wife (for example)is totally blind and has been since birth. Some of our friends have glass eyes. Some of these people have never seen an ophthalmologist as</p>

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	<p>there is nothing that can be done to improve the condition. Yet they are now asked to prove their condition.</p> <p>6) Access to clean myself, be dressed, access to toilet facilities, being safe in a secure environment without fear of external forces. In short to be able to lead as normal life as possible. We do not want to climb mountains or indeed have any sort of holiday, but we do want to be independent of whims and prejudices of red tape.</p> <p>8) I have considerable adaptations which I use including ground floor living. These could be used as an indicator of the physical requirements for payment criteria.</p> <p>9) Previous claim answers must be taken into consideration instead of the practice of making the person repeating answering the same question over and over again for different claims. It is sufficient to ask if the condition has changed.</p> <p>10) Declarations from existing medical consultant should be the first port of call. Only when this is contrary to the claim should further information be necessary.</p> <p>12) Many conditions do not require reviews. Disabled since birth. Blind since birth ect. Seek out only the conditions that are likely to improve and allow the disabled person the ability to reclaim should their condition worsen.</p> <p>15) In my experience some people have a "Whats the point of claiming I wont get it". mentality. A telephone/internet question and answer site could help the claimant see if the benefit is appropriate.</p> <p>16) Yes</p> <p>18) I have no knowledge of passport services. Where is this information to be glamed?</p> <p>?) Fraud should be looked at as there are some people claiming that do not need it. However it is wrong to re-evaluate all present claims where the case is already proved above doubt. To do this is a waste of money.</p> <p>11) There is no need for this where the condition/requirements are well proved over an extended time. This can only lead to undue stress and exposure to the whims and prejudices of individuals doing the face to face work. Where required the meeting must be made with a home visit. Then the interviewer can see the extent of difficulty in a home environment.</p> <p>4) Yes</p> <p>8) Previous claim answers must be taken into consideration instead of the practice of making the person repeating answering the same question over and over again for different claims. It is sufficient to ask if the condition has changed.</p>
ONLINE534	<p>1) Problems or barriers can include -</p> <ul style="list-style-type: none"> <li>- The nature of that person's disability - if they are physically disabled they may not be able to play sports for example. If they are mentally disabled (like me) they may be too anxious to function in everyday society.</li> </ul> <p>Some stresses include -</p> <ul style="list-style-type: none"> <li>- Bigoted politicians who want to save a few pennies by making vulnerable and disabled people even more vulnerable by helping them along the path to poverty. The stresses of this change to benefits will especially effect mentally disabled people and those with psychiatric problems - I know that, for myself, the anxiety and stress if my benefits were lowered would lead to self harm, erratic behaviour, and possible suicide attempts. Because I would have less money to live on, I would not be able to afford extra costs due to my autism, such as taxis when I am too anxious and depressed to walk or use the bus, and extra technology needed to keep in touch with friends and help my mental health - as I am sometimes too anxious to meet them in person or use a phone.</li> </ul> <p>Not just the anxiety about having my benefits lowered - the anxiety of having another review. Last time I had one it put me under so much stress I had to go and see my psychiatrist and she upped my medication. Especially people with autism will suffer greatly from these changes.</p> <p>Other barriers include..</p> <ul style="list-style-type: none"> <li>Lack of money</li> <li>Discrimination</li> <li>Depression</li> <li>etc.</li> </ul> <p>2) All of it. There is no need for it to be changed - sure it is a little confusing, but so are all the benefits.</p>

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	<p>This is just a callous attempt to get 300 odd thousand or so people off the benefits system. You are taking away not just peoples' independence, but peoples' very LIVES.</p> <p>4) The obvious disadvantage/ problem is that people on Middle rate care will end up on the lower rate. Again, a callous, heartless way to save money you guys spent...</p> <p>And no, it won't make them easier to understand and administer. As for appropriate levels of support, that's a big fat NO as well.</p>
ONLINE535	?) STOP THEIR MONEY
ONLINE536	<p>1) My husband had a major stroke 3 years ago and needs full time care provided by me, I have no help, nor do I want any. It is ridiculous to suggest that he does not have barriers that stop him leading a independent full and active life and be able to participate in society, I feel it is insulting and quite ignorant to suggest that unaffected society even want to know. I would welcome a member of parliament to come to my home and ask him for his response (he is extremely intelligent) and receive some inside education.</p> <p>Personal Independence Payment??? No for us it is Disability Living Allowance!</p>
ONLINE537	<p>7) an assessment should be carried out every 10 years and all circumstances are to be taken into consideration plus there should be an independant assessment carried out of the households circumstances and how that effects there lives. i also feel the people who are carers and deal with the disabled person every day should be relied on to give the best possible assessment and a carers statement would help in doing this e.g the carer would have to fill in a form every 2 years disigned to help the discition maker see how the disabled persons situation changes</p> <p>8) i feel the assessment should take into account both aids they have and aids they could have i also would say counting a carer as a aid adaptions also mean they can help themselves better however these should not be used as a tool to take away benefit because things become easyer they should be used as a tool to say a person is trying to help themselves and benefit should be made available to help give these adaptions and aids a carer should be classed as aaid and the disabled person and carer should receive a allowance for this if a person has a carer that is and it should be ontop of there usual benefit this would aid both carers and disabled people.</p> <p>9) the form is too long and needs reducing i feel repeating questions and/or making questions be the same but wrote a different way should be stopped. i aslo think that asking a disabled person to assess themselves is wrong for instance asking a individual to say how far they can walk this can vary depending on the circumstances i feel it would be far better to say can you walk 100 yards simple yes or no answer and the how long does this take you question should be took out all together make the form less complicated and only ask the question once.</p> <p>10) gp and helthcare professionals and and other state appointed professionals are not with the disabled person day by day the only way to get a clear picture is from the person themselves and there carers i would say if a person has a named carer then that carer should get a form to fill out every year or two years to help give a clear assessment of the disabled persons situation, by all means gp and helthcare professionals should be part of the process but the carer is the person who deals with the person regulary a assesssment officer of helthcare individual can only assess on one day not weeks months and years like a carer can.</p> <p>1) the main problem is an employer would rather give a more able person the job than a disaled one i think this has to change. that is if a disabled person wants to work it must be left to them and not the government to say who can or cannot work.support should be given by there gp surgery to manage there condition and in conjunction with a carer if they have one,and it should be made a condition of benefit that they attend these consultations also it must be made a condition that the gp sends a report to the department responsible for this benefit every 6months to state how the disabled person is managing there disability and what improvments are made this should not alter benefit but would help with any future assessment build up a framework of the individuals circumstances.</p> <p>2) yes once the benefit is assessed as being for life it should remain for life and the disabled person should not be assessed again or be reviewed however they would still have as part of the conditions of the benefit have to attend the gp's clinics for instance if a person has asthma this is for life they should receive the benefit for life but have to attend</p>

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	<p>the gp's asthma clinic once a month so management of the condition can be controlled.</p> <p>3) being cared for in there own home and the adaption of there homes so they can remain in society, and aids. the biggest expence is there carers a carer should be given a extra benefit so they dont go into povity at the moment a carer who gives up work to care for someone gets income support and carers allowance, i feel that these benefits do not reflect the work they do i feel replacing both benefits with one benefit for careing would be better eg roll them into one and increase the benefit so the disabled person gets the best care and the carer gets a good payment and are not on the breadline like many are.</p> <p>4) the one disadvantage could be if a disabled person is in the middle a dicission maker would have to make a dicision that is not acceptable to the person involved the easier way would be to define whats long term and what isnt if a person has a short term illness that could get better then the low rate would apply and they would be regulary assessed if its a long term problem that wont get better eg its for life then the higher benefit should be given and they should not be assessed.</p> <p>5) automatic entitlement should remain on certain conditions as they are now</p> <p>6) support should allways be given to terminly ill patients, i feel that whilst every disabled person has a right to seak work or be in work this should be done only if that person wants to engage in work that they can do both physically and mentally they should not be made to work if they dont want to. i think every circumstance should e taken into consideration and all points of view from the person who is disabled, the medical profession, and the carers and and independant assessment should determind if the disabled person can work but this should be done only if the disabled person wants to work and work is available they can do benefit should not be taken away from them ever as many rely on it. a persons ability to do thing around the home should be taken into account what they can and carnt do however just because some one could say cook a meal this should not be used against them.</p> <p>14) advice from there gp and healthcare specialist only</p> <p>17) teachers should be involved in the assessment and all heathcare professionals should carry out independent assessments</p> <p>18) it has been very helpfull however i think it could be improved to make this available for the disabled person to use this for buying aids and adaptations</p>
ONLINE538	<p>1) Lots of access issues make life difficult and some buildings impossible to enter. There is also reluctance by employers to take on disabled people who they may view as more likely to take time off work than able bodied people. This is particularly the case in a recession.</p> <p>Often disabilities are not understood by the public and this can also create a barrier.</p> <p>3) Extra costs in travel, caused by difficulty of getting about - need to use the more expensive modes of transport.</p> <p>Also extra costs of specialist equipment, eg mobility aids, wheelchairs etc and extra items to fulfil medical needs.</p> <p>Also heating and power costs due to being at home more during the day than the average person.</p> <p>8) Should also consider future needs, particularly with regard to deteriorating conditions. More money to be made available for wheelchair services.</p> <p>Also important to continue with housing grants for adaptations to properties.</p> <p>All aids and adaptations should be included.</p>
ONLINE539	<p>18) I think the 'passporting' is really important. For example the mobility bus pass and motability scheme are very helpful for people and can have a really big impact on peoples' quality of life.</p> <p>19) I think this would have a very negative impact on a lot of people. The bus pass in particular and the motability scheme enables people to access their communities more easily, helps reduce isolation and improves quality of life. Additionally, 'passporting' means that people are not having to be repeatedly assessed, which can only be a good thing for them and service providers.</p> <p>10) As well as the person concerned, a range of people should be able to provide evidence, such as GPs, Social Workers, Consultants, Physiotherapists, etc etc. Those involved in the person's 'care' and who have relevant information.</p> <p>11) I think that this needs to be thought through very carefully. The interviews that take</p>

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	<p>place for ESA are resulting in a lot of people 'failing' the medical, i.e. being found fit for work, and then having that decision overturned at appeal some months later. This is creating a lot of distress and anxiety for people who are already unwell. It is also creating a huge amount of time-consuming work for people like me who are employed in the social care field or at CABs and now spend the majority of their time going to appeals with people, writing supporting letters, filling in lengthy forms, etc. I would not want this to happen with DLA/PIP too. It would need to be thoroughly transparent because some people think that the independent medical professionals are being employed to get people off benefits. This is not an unreasonable assumption given that many are having their appeals upheld. Additionally, I think lots of people struggle to get their health problems across during an interview, particularly those with mental health problems or difficulties. I regularly support people to medical interviews at the moment and I find that those people usually get a positive result. Unfortunately I think that the presence of a Social Worker or other professional influences the process and that seems unfair for those people who do not have anyone to support them. I wonder whether people might slip through the net or not get their full entitlement because of this process.</p> <p>14) As long as it does not become a way of getting rid of people, i.e. just signposting on.</p> <p>15) I would be very wary of this. It could potentially be very difficult as it could be seen as blackmail, i.e. if you don't do this then you don't get any money. Surely people are either entitled to benefits because of their health or they are not. They should not have to jump through hoops to get it.</p> <p>16) Some of them are funded by the Local Authority or NHS and people don't always have to pay, which I think is right. I think if a one-off payment would meet someone's needs then why not? But it would have to meet their needs.</p>
ONLINE540	<p>1) Stigma, lack of care and understanding. Personal circumstances relating to the disability</p> <p>2) The DLA should not be tested by ATOS or similar. There is no need to get a midwife to decide whether someone has a significant mental illness (as per esa). A specialist's consultation has been taken on each of my claims and there is no need for other interference</p>
ONLINE541	<p>1) The attitude of other people - prejudice, lack of understanding, lack of willingness to try and understand or make concessions; lack of opportunity; lack of money; lack of appropriate roles. We have high unemployment as it is - how is someone like my son who has autism spectrum disorder supposed to get a job when only about 15% of people with an ASD end up in employment of any sort? My son has no friends, he has phobias, we are unable to go out much as a family - it is not only the person with the disability who is not able to participate fully in society - it is the carer too. Making it harder for people with a disability has a knock on effect on the carers and family too.</p> <p>2) You need to think carefully about how people who have a developmental disorder like autism fit into your image of disability. The forms at the moment aren't easy, but they do allow for people to describe their day which is especially valuable for those people with autism. Disability isn't just about mobility, sight or hearing - my son is perfectly able to talk, see, move, hear. He is able to pick up a pen off the floor and do probably most of the tasks that will be required to assess him. Yet I think it will be very difficult for him to find a job or someone willing to employ him. He has autism spectrum disorder and is quite bright. But his social deficits are large and he does not fit this model of disability. How is he supposed to support himself as an adult? He will be chased up by the unemployment benefits system, yet no provision or income will be made for him to try and get him into employment. How can it be when unemployment is increasing daily, one fifth of young people being unemployed and only 15% of people with ASD have any form of employment at all? How is he going to compete with all the other people trying to get jobs? I think having special assessors, who mostly probably will not know much about autism and the way it affects people so differently, who will be looking for a one size fits all approach, will not give a true assessment of the person's life. You need to ask people who know the person, who deal with the person regularly to assess them - not strangers who do not know the person at all.</p> <p>3) Not being able to work due to their disability; transport to appointments; paying for extra care and support; buying equipment or things that make the person's life easier.</p> <p>4) Again, you need to consider people who don't have a physical disability, but have a developmental disability like autism, or a mental illness. These people may be well able to pass a few physical tests, but may also be unable to hold down a job or even be</p>

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	<p>considered for a job due to their inability to function successfully in the world. The danger of this being "awarded on the basis of the individual's ability to get around, the other on their ability to carry out other key activities necessary to be able to participate in daily life" are that you have a range of tests that will not allow for mental illness or communication disabilities like autism/asperger syndrome.</p> <p>5) Some health conditions should mean an automatic entitlement - my son's autism is a LIFELONG DEVELOPMENTAL DISORDER - it is not going to go away. He will always have difficulties functioning successfully in daily living. He may never be able to get a job. This does need reviewing to make sure needs are continuing to be met - but not accepting that some disabilities simply can't be wished away is irrational. It means that the goal posts can be moved at any time.</p> <p>6) Being able to afford food. To be able to have social interaction with others. To have friends or to be helped to have friends. To be able to get around safely. To be able to have something to live for - a job, something to do, friends.</p> <p>7) Have regular reviews, as at present where we have to do the forms again every 3 years.</p> <p>8) You should ignore the aids. Having a wheelchair might make things easier for the person with the disability, but it doesn't make it go away, they are still dependent on it, not all areas will be accessible, they will need adaptations in cars and public transport. Saying that they have the same advantages as someone with out a wheel chair is ridiculous.</p> <p>9) I don't think you can make it much easier. It is necessary to gain all the information you need. You could improve information about the benefit by providing booklets, a website where you can answer questions to find out if you are eligible and a phone helpline.</p> <p>10) You need to listen to the people who KNOW the person - the parents, the carers, the doctors, teachers, paediatrician, psychiatrist, family and friends, as well as th person themselves if that is appropriate. To ask an independent person who has no knowledge of the person, who cannot have a good knowledge of all disabilities is most unfair on the person with the disability.</p> <p>11) Can't think of any benefits - you will be employing people to do a job that their own doctor could do. How will this save money? They cannot have a knowledge of all disabilities and cannot have an understanding of each individual because they won't know their case or what it is like to live their life. Carer's are the people who are most likely to know this.</p> <p>Circumstances where it may be inappropriate - this could vary from a terminal illness, a person with a phobia of authority figures, a case where travelling is difficult to do. Each case is different.</p> <p>12) Criteria should depend on whether the condition is life long or not. People aren't going to stop being quadroplegic/blind/autistic. There needs to be reviews to check that these people's needs are being met every few years in these cases. Conditions that are not likely to be permanent may need reviewing sooner.</p> <p>13) Write to them every year?</p> <p>14) Information about what entitlement they may have, how to apply, what the benefits are likely to be, what is involved. This would be useful as part of the benefit claiming process, but also in hospitals/doctors surgeries. Most people are not told about DLA by a health professional - they are told by other users or carers.</p> <p>15) You can't make people access advice and support. You need to make sure people know about what advice and support is available, but you can't make them access it.</p> <p>16) They use DLA and grants. Yes there should be an option to use PIP to meet a one-off cost, but I think it is more for daily living.</p> <p>17) You should make sure you listen to parents, carers and other people who work with the child. Using assessments to assess SEN could work, but people are finding it more difficult to get statutory assessments these days, so that may not work. But consulting with people who work/live with the child is vital.</p> <p>18) In our area you cannot access the social services disabled children's team without DLA at middle or higher rate. So this is very important. Also, I am not able to work because of my son's disability, so being able to claim carer's allowance as a small compensation for not being able to work is vital. It enables me to stay sane and to give my time to dealing with my son, education, health, social services, benefits etc</p> <p>19) It means they would suffer.</p> <p>20) Education/school/health could be shared with assessment for disability.</p> <p>21) Unsure.</p>

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ONLINE542	<p>1) Other people's attitudes. Nobody is willing to make reasonable allowances for those with difficulties. Nobody actually does get up on the bus for the old lady with a walking stick. People will scoff at you when you tell them you are disabled if you don't "look" disabled. The cost of gas and water make it impossible to stay warm and manage physical pain. It is impossible to manage a personal and work life when your body won't cooperate without proper and tailored assistance. Buses aren't friendly for people who suffer pain. They're largely inaccessible with wheelchair spaces often occupied by prams and the seats are painful. People will kick your walking stick from under you if you walk on the pavements and will park in the blue bays without blue badges. Cooking a meal is impossible for me to do unassisted. No disabled person will ever be truly independent which is a barrier with itself. Until people realise that disabled people need help and incur extra costs, they'll not get anywhere.</p> <p>2) The only thing which needs to change is the traumatic application process. The applicants own doctors get ignored and strange doctors make a decision based on their snapshot views. Consultant opinions should be the primary source when making a decision. The appeals process and application process is humiliating and exhausting.</p> <p>4) Doesn't DLA already have two rates? As it is, I believe the criteria is too generalised and doesn't cover complicated conditions.</p>
ONLINE543	<p>22) Proposed cutting of the Mobility Element in DLA for residents in Care Homes..</p> <p>This will have a huge and regressive impact on the independence of thousands of disabled people. Disabled people in means-tested residential care are already forced to manage on incredibly low incomes, often receiving just £22 a week in the form of a Personal Allowance to meet all of their personal costs.</p> <p>DLA mobility component provides absolutely vital support for people to remain independent and to meet some of the additional costs of getting out. The average payment per person the government plans to cut is £33.40, although actual payments to each individual are either on the lower level of £18.95 per week or the higher level of £49.85</p> <p>Removing DLA mobility component from people in residential care will have a devastating impact. People will not have the money to meet additional mobility costs such as a powered wheelchair, accessible taxis or a Motability car and this will seriously impact on their independence.</p> <p>Whilst in some cases limited transport provision is included in residential care fees, this covers only communal or very limited independent transport. It does not provide the freedom offered by mobility DLA. This will result in people being trapped in Residential Care Homes.</p> <p>Nationally, it is estimated that over 74,000 people will be affected by this cut if implimented.</p> <p>1) The disabled person should be paid an allowance sufficient to employ 2 full time carers. As parents to a now 36 years old disabled son and taking into account all benefits being paid, we provided care 24hrs 365 days for less than 50p an hour. I have experience of carers who have lived out their lives in virtual poverty having had to give up their jobs. The Prime Minister was able to manage his late disabled son's care by using private resources. Professional people like myself and my wife were able to work flexibly and so manage the care of our disabled child together with our other two children. This flexibility is not possible for those in low paid work with inflexible hours. The combined benefits currently available are an insult and constitute poverty wages.</p> <p>2) On a personal level, my 36 year's old vaccine damaged son will suffer. At present, he lives half the week in our home and half the week in residential care. To drive him to and fro requires (8) 12 mile journeys each week. We his parents are both pensioners: 71 &amp; 65 respectively and will not be able to fund the short fall of removed DLA mobility. Another area that does not appear to be considered is the negative effects on Motability: many of these users combine their entitlement between home and residential care/respite services</p> <p>8) This proposed distinction places the disabled person in a double-jeopardy situation. There already examples of disabled soldiers being denied DLA mobility component once they become mobile with the aid of prostheses. A person's disability should be assessed</p>

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	<p>independently of wheelchairs/prostheses etc.</p> <p>9) The current Application Forms are disgracefully long. The PIP Application Form should be no more than two A4 sides and be completed between the GP, the Applicant or their legal proxy.</p>
ONLINE544	<p>13) send a letter asking them to inform us of any changes that may affect them</p> <p>14) cannot answer this question as i do not cover payments</p> <p>15) i have no idea</p> <p>16) through their benefits....yes there should be</p> <p>17) ages,not quite sure</p> <p>18) i have no idea what this question is on about</p> <p>19) do not know</p> <p>20) dont know'</p> <p>21) i haveno idea'</p> <p>22) Thanks for the consultation previously not sent to team i have just lost an hour off my work and i am now starting the work later than normal i do hope you find that this is useful to you. Please consider how much time is taken from all members of staff bearing in mind the high work loads and pressures of stats having to be filled in daily.</p>
ONLINE545	<p>3) how about breakages for someone who is autistic. Many extra costs are not quantifiable and happen as they occur. THAT is the beauty of DLA. It is flexible. Clearly you want to pare down the help to the disabled using clever catchphrases as your justification</p> <p>5) yes of course they should. It's a no brainer. if you are blind you need to get around and therefore have needs. Even the most stupid Permanent Secretary should be able to see that</p> <p>15) yes why don't you sanction the disabled and cut their benefits. You are really despicable</p> <p>?) yes leave well alone</p> <p>?) are you stupid? What would be the effect if I brought an axe down on the head of the idiot who dreamt this question up? Simple isn't it?</p>
ONLINE546	<p>8) NO. The focus should not be on the technology used to paper over the disabling barriers (I use magnifiers which constantly break and leave me back at square one until a replacement is provided) but consider the barriers which people may face and continue the efforts of the equality act to remove disabling barriers.</p> <p>9) I would still go to an independant disability charity for advice on filling out any benefit claim. I no longer have any faith or trust in government advisors on benefit entitlement. On more than one occasion I have been given wrong advice and usually in the governments favour.</p> <p>10) Medical evidence of impairment from the person's GP or specialist. The cost of providing the medical evidence (such as any test, report or letter) should be refunded by the DLA. A disabled person should not be out of pocket because they have to provide information in order to claim a benefit to help with extra costs.</p> <p>11) Would anyone feel comfortable with discussing their personal circumstances with a person they have never met. I would not as it is my personal and sensitive information and it would feel like I was in a glass fish bowl.</p> <p>13) Improve the DWP's image with benefits. I fpeople feel confident that DWp staff know what they are doingthen people may have more confidence in informing them of changes to circumstances without wrong decisions and lengthy resolution times.</p> <p>14) As previously mentiond I would go to an independant disability charity for advice and support.</p> <p>16) My hand held magnifiers are provded through the NHS and this should continue. My other aids such as a portable CCTV approx £2000, PC, large print keyboard, lрге PC screen, ergonomic chair and screen magnification software(LunarPlus and ZoomText) were funded by DSA, the later in particular is essential in enabling me to access both a pc and the internet. In my experience and that of my disabled friends the DSA has been the easiest means of aquiring funding assistance for essential ergonmic equipment and accessibility technology.</p> <p>?) It is highly infuriating when you have to provide the same evidence of your impairment for housing benefit and JSA.</p> <p>?) More headaches, inconvenience and paperwork</p> <p>?) The DWP needs to do real work in improving their image ith regards to disability benefiuts as a whole. In my experiene the general view of the DWP is one of intimidation</p>

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	<p>and incompetence with the aim of giving out as little money as possible.</p> <p>1) The legacy of an infrastructure and society which does not value diversity and continues to fail in recognising the social model of disability. Stop treating disabled people as medical and look at the factors which disabled people in different ways and start removing them. I have found most of the language used in this consultation negative and offensive.</p> <p>2) Lifetime awards. My condition is genetic and permanent. I find it offensive and insensitive that I may have to have periodic reviews, especially as this might mean time off from work, the involvement of more medical professionals, a complete waste of paperwork and admin costs.</p> <p>4) Two tier rates is irrelevant if the payment does not take into account the increased costs in society (not simply going up by approximately £2.50 per week a year). The DLA payment therefore becomes less and less helpful in overcoming extra costs incurred.</p> <p>5) Any impairment should be an automatic entitlement to DLA as people will face disabling barriers.</p> <p>6) This question is offensive and degrading. Life is not about 'essential activities' but living life to its full potential. An activity may not be essential for everyday life but may still incur extra cost due to disabling barriers.</p>
ONLINE547	<p>1) I am a mother of two severely disabled children, my children will never be able to live independent lives as they need 24/7 care. They will always need residential care this helps us so much to cope with our families needs and gives me and my husband time to re-charge our batteries and spend time with our other child. The only problem is we don't get enough help and every year we are fighting to keep the respite that we have. Our children need 1/1 support at all times and will never be able to live independently or participate in society.</p> <p>3) As a mother of two severely disabled children, we rely on their DLA so much, this helps us allow them to buy them good fitting shoes and we need this money for petrol costs to get them to all of their hospital appointments. This also contributes to extra equipment that they need which the trust doesn't supply. Without this we wouldn't be able to afford what the children need or afford the petrol for our car to get them to hospital appointments. It's a real life line for us.</p> <p>5) Yes definitely, the more severely disabled children and adults should automatically be entitled to the benefit, this should also include children with severe disabilities who do not have a diagnosis.</p> <p>10) I think if you have a social worker that he/she should be asked to comment on your child's or adult's disability as well as your GP. As well as the carer to give a detailed account of the child's/adult's needs and disabilities.</p> <p>8) Not all people with disabilities have made adaptations or use aids, so this should be looked at very carefully, but the person can still have a severe disability without any of this</p> <p>?) This category of people should get extra support both to them and their families who look after them - they should receive their benefits faster than other people and social services should be offering these people extra help and respite to enable the family to cope</p> <p>9) For a start the forms shouldn't be so repetitive, and shouldn't be so long and take hours to fill in.</p> <p>?) It is vital that we keep receiving DLA for our severely disabled children, without it we couldn't afford things for the children which the trust don't provide and most of all it helps us maintain our car and pay for petrol to get the children to all of their hospital appointments. It is such a life line for us, but the DLA process could be easier and forms easier to fill in etc.</p>
ONLINE548	<p>1) The biggest problem that I have of leading a full independent life is I'm Disabled... I can drive so that gives me some independence but if you asked me to go to town, I would be afraid of falling as my balance is bad, and people don't stop to help so I would be alone and unable to get up if I did fall. This prevents me from being able to get up and go where ever I wanted. Instead, I have to wait for someone to come with me.</p> <p>Abuse and discrimination from the public can also be an issue, so that makes me nervous when I'm out alone.</p> <p>As a disabled person, another area I struggle with is to find social activities locally that are disabled friendly as this is one area that is lacking in West Wales.</p>

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	<p>The other problem I would have is something simple like doing the shopping. First I wouldn't be able to get most items off the shelves, then I would struggle carrying the stuff into the car.</p> <p>2) I hope that the option of using the Motability Scheme will stay the same. As a disabled person, I couldn't leave the house independently without a car as I live in West Wales where the areas of convenience are too far for me to manage to walk and on top of that, I live on a hill. I'm now signed up to the Motability scheme which provides a car in exchange for the mobility part of the DLA. If this benefit changes, what happens about this scheme? Are all our cars going to be repossessed?</p> <p>3) One area that I believe disabled people spend more money on is on heating. A person who is disabled always seems to be naturally colder than an able-bodied person, which means that heating bills would naturally be higher. As a disabled person, the other area I spend money on is to get around using my car as I could never walk a long distances. Despite having a free bus pass, I could never manage getting on or off the bus independently which means that I rely on my Motability Car to get everywhere, the rising petrol costs obviously hits the pockets hard. Another area I spend more money on is buying gadgets and special equipment to gain independence in every life such as special tin openers, jar openers and peelers to name a few. These items are disabled friendly which means one thing, they are never cheap but essential in some cases. When shopping, I can't go out and buy any shoes out there, as I suffer from severe Rheumatoid Arthritis, I have to buy good quality shoes which I pay heavily for but they do help my feet. The other life-line I, and I'm sure other disabled people have is the Internet. I don't count this as a luxury but an essential tool that I pay out for each month. The Internet to me is a connection to the outside world, regardless of how ill I feel, it's nice to know that I can always fall back on my PC. From my computer, I can communicate, shop online for groceries or whatever else I need, and keep up with real world events, even when I'm too ill to leave my home.</p> <p>6) This is the one question I dread as this is the area that is a nightmare to assess. I'm suffered from severe Rheumatoid Arthritis since I was 8 years old, so over 20 years now and in that time I've had hips/knee replacements and still I'm in chronic pain. The biggest problem I have with this question is (a) the actors of this world, who will go into an assessment and lie their way through and (b) people like me who are severely disabled but who choose to participate in society by working and driving a car. Out of those two groups, who is the assessor going to prioritise and give the new benefit to? Everyday I work with disabled people and everyday I tell them to keep their chin up and make the best of the hand they've been dealt, try and make the best of a bad situation. My biggest problem is that people who make the effort will be penalized, and the actors of this world or simply the people who are able to work but who choose to give up on being part of society, will be the ones rewarded. When I go to work, I ask myself every time, why do I do this to myself when my body is screaming in pain and clearly wants me to stay home and relax, but the truth is simple. When I'm home, even though the day flies by, the only thing I feel at the end of that day is the feeling of emptiness and worthlessness. By working, I've contributed to society, earned my own money and met up with people outside of my circle. I guess the question is, how can an assessor look at me who drives a car and works and then assess someone who comes in and says I can't drive, I can't work, I'm not good enough to leave the house and still look in my favour. It doesn't mean that I'm more healthy or able-bodied than the other person, just that I push myself to work, to drive, to try and be independent regardless of the rubbish hand I've been dealt health-wise. As far as the activities that a person can or can't do, I can't get in/out of the bath which is the reason that I had to build an extension onto my bungalow to house a new shower. I find peeling potatoes or any hard vegetables to be impossible as is lifting heavy pots and pans or opening bottles/jars. Getting down or up from the floor is something I have never been able to do. Also, I haven't been able to reach my feet for years, due to the limitation of Arthritis, which means that putting on socks or shoes is someone else's task, as is housework.</p> <p>8) The assessment should take into consideration if a person has aids either on a constant basis or also occasional use as many conditions fluctuate daily and a person might need</p>

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	<p>an aid one day but not the next. As for adaptations, it depends what the adaptation is as some adaptations are temporary, put in after an operation for example, where as others are permanent.</p> <p>10) I want to say the GP but I fear that putting the responsibility in their court will put them in a position where they could be harassed, nagged or even threatened in some cases. Why can't the assessor look at medical records such as x-ray, the medication being prescribed, and predictions (if there is such a thing) by a number of doctors treating each patient? I know from personal experience, I have a GP, 3 surgeons and 2 consultants who work on this tired body of mine. Why can't all their written opinions be counted within the medical file, isn't that what they do after you leave their check-up appointments? Also, should house-holds who have a reduction in council tax due to having been assessed for disability have that taken as supporting evidence? After all, that means that an assessor has already been inside that person's home to assess the home itself and been approved. In my opinion, that should count as supporting evidence, with the medical side proving the physical disability evidence.</p> <p>12) It should depend on the condition itself, as some conditions can improve over time, such as stroke survivors, depression and palsy where I've known some amazing people who's made a full recovery. Individuals should also be reviewed based on how long they've been ill with the evidence in their medical record backing this up. People with long-term illnesses who rely on carers 24 hrs a day who are never going to get better should be re-assessed every 10 years, with people who are also long-term sick but who might not rely on carers should be re-assessed every 5 years. People who have conditions that might improve should be assessed every 2-3 years.</p> <p>As for the evidence, a form of some sort should be sent to the doctor treating the condition asking such questions as, Has the patient improved/deteriorated in the past X amount of time, do you have medical evidence to back this up such as x-rays or other medical tests, does the patient take more/less/stronger/weaker/same medication now, do you foresee any surgery for this patient in the near future due to their condition.</p> <p>17) Assessing children is difficult. I'm an adult now but when I was 9 and I was assessed for DLA, I did what I was taught by my parents to do when in public, which was to always be polite and not complain or miss-behave in public, after all, if you pass someone on the street and they ask how you are, regardless of how you feel, you don't make a list for them do you. I also looked on the assessor like he was the headmaster of my school so in the assessment, I stood to attention. End result, the assessor asked me if I was in pain, I smiled and said that I was fine, he asked if I found things difficult, I said that nothing was a problem, I did everything my friends did. Everything was good and everything was amazing. Reality was, I was in agony, I could hardly walk, I resembled a robot when I did walk, I was in Physio 3 days a week, I only went to school for an hour a day and I was heading for 2 hip replacements, 2 knee replacements. Few weeks later, my parents had a letter to say that I wasn't disabled enough to have DLA. This decision was later overturned but as a child, I didn't understand that I needed to tell the "assessor" the whole truth and nothing but the truth and my parents refused to "tutor" me on what to say as they thought that would be a horrific thing to do to a 9 year old and also they believed my condition spoke louder than words.</p> <p>Taking a child into an interview style room like I had wasn't good. The assessor should assess the child in a play area if that's possible in order to come across more like a friendly teacher, rather than the headmaster who's got all the authority.</p> <p>18) The biggest implication I can see is for services like the Motability Scheme, blue badge scheme, bus pass, cinema pass, and others. All of these rely on proving that you have DLA, so if a person lost their DLA, they would also lose the services that's linked into it also.</p> <p>15) In theory this is a good idea but the claimant should be actively encouraged rather than forced. It is also vital that each case is dealt with on its own merits</p>
ONLINE549	<p>1) Speech problems, hearing problems, mobility, neurological conditions. Being unable to communicate effectively is the biggest barrier. (Social Exclusion)</p> <p>2) Mobility element</p> <p>3) Paying for support workers. This includes help with washing, dressing, shopping, emotional, and personal support.</p> <p>Disabled people can't always use the same transport as other members of society and often need to use taxi cabs and other methods of transportation.</p> <p>Aids and adaptations</p>

Respondent Number	Response
	<p>Lifeline support Meals on wheels</p> <p>4) In principle it should be easier to administer and easier to understand, however there is a danger that cases wouldn't be scored on an individual basis (more likely to be categorised) and having too many components would provide more opportunity for error rather than to cut down on human error.</p> <p>5) neurological conditions should have an automatic entitlement because brain conditions are amongst the most difficult to live with as they affect you in so many ways</p> <p>6) Social Exclusion is the most important factor. Unless claimants receive meaningful targeted support they become socially excluded. Mobility and being able to attend social groups are essential for social inclusion</p> <p>7) an annual (short) questionnaire should be sent to the claimant. This will ensure all information is up to date.</p> <p>8) The assessment should take into consideration the aids and adaptations that the customer uses, however, the decision shouldn't be made purely on the basis of which adaptations the customer uses and which ones they don't. Not all disabilities require the use of aids and adaptations.</p> <p>9) The form should be as simple as possible to follow. A flow chart style form would be highly advantageous. More often than not the language used in forms is confusing and isn't as plain as it could be. If forms aren't constructed in an easy to understand way then this just adds to the anxiety of the claimant.</p> <p>10) The customer (claimant) is best placed to supply this information, assisted by any relevant carer and supporting information should be provided by the health care professional. The customer is the person that knows their condition better than anyone else.</p> <p>11) It is paramount that the healthcare professional has a good understanding of the customer's medical records. Whilst in theory it is very important that face to face discussions take place it is equally important that the health care professional is in possession of as much information as possible as to the individual's circumstances. It would be inappropriate to have a meeting in some circumstances as the customer may have some serious underlying conditions that puts the healthcare professional at risk, it would be impossible to have a 'one size fits all approach'</p> <p>12) The frequency should depend upon the history of the condition. If the condition has remained unchanged for a specific period of time then the review should be less frequent. I think in the early stages of a claim (the early years) a review should occur annually, if there's no changes during the first three years and the claimant still needs the payment then the review should change to three years. Again after three years if the condition remains unchanged and the claimant still needs help the review should be in five years time. I don't think it would be cost effective to have an annual review regardless if there's a pattern of a few years without change. However I do think it beneficial to send a simple form on an annual basis just asking; 'Have your circumstances changed during the last twelve months'</p> <p>13) Send the claimant a simple form with one question on. I.E. Have your circumstances changed in the last twelve months that may affect your claim? The more simple the better</p> <p>14) I think that this is a fantastic idea providing it is administered properly. The more assistance that can be provided by way of signposting towards help and support the better then individuals circumstances will be.</p> <p>16) Yes there should be an option available to use Personal Independence Payment to meet one off costs</p>
ONLINE550	<p>1) Health and Safety rules. Insurance issues, (ie. can't get cover) People having the wrong impression of what being disabled is about.</p> <p>3) Those with physiological conditions such as heart disease have additional costs such as prescriptions and even food bills if on special diet. For me, having non-operable heart disease my meds bill equates to over a £140 a month. I have to claim for help via an HC2 exemption certificate on an annual basis. If I had diabetes for example, I would get free prescriptions automatically.</p> <p>Further to this question, transport is an issue which is where the motability scheme comes to the fore. Without it, I would be stuck. May be worth noting that I see this part of DLA a privilege not a right. It allows me some freedom to get about even if only to do the shopping.</p>

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	<p>5) If the condition is biological, as in Diabetes, Thyroid, kidney/renal failure yes, entitlement should be automatic. Conditions like mine, Non-Operable Coronary Heart Disease should also qualify. Mine is a physiological condition in which there is no cure and surgery would not be of any benefit hence severely restricted. I need to take large amounts of pills and potions at all times of the day and into the night yet my condition isn't recognised as much as biological conditions. Cases such as mine and those with biological conditions are easily checked, verified and the affects of such conditions are well known anyway. Some types of diabetes I know are easily controlled via diet but type 2 can lead to other health issues.</p> <p>There is no 'grey area' for heart disease. No by-pass op, means no improvement in the condition. (as in my case)</p> <p>7) Any assessment has to be based on the worst case scenario. In other words, what happens on the days that a claimants condition is at its worse. For example, in my case, a seriously bad day means I can't get dressed without triggering an Angina attack with breathlessness.Its not that bad every day but it sure makes things 'unpredictable'.</p> <p>8) I would say yes to part one of this question. It should also take into account medicines that have to be taken throughout the day and the side effects that can and do occur. This affects the ability to do things as well as the condition. Also the potential for a condition to deteriorate over time should be taken into account.</p> <p>9) By including specific conditions that are known, medically, to affect a persons ability/disability. For example, Coronary Heart Disease, Renal issues, Loss of limbs. For example, Asking someone like me with CHD if I can turn a tap on is ridiculous, has no bearing on my condition.</p> <p>Not once have I been asked if weather conditions affect me, which it does, quite badly in fact yet its not taken into account. Too hot I'm in trouble, too cold even more trouble.</p> <p>11) It needs to be someone with knowledge of the condition. No point seeing a doctor or nurse with no specialist knowledge on a particular condition or disability. An example I can quote, I saw a doctor who was a cancer speciallist who actually said in interview he didn't know a great deal about heart related issues and was relying on further reports from my own GP and cardiologist. This caused major delays waiting for additional reports. This part should/could be done quicker by all medical reports being obtained at time of claim so the DWP Doctor has all the relevant medical stuff available. Based on this a decision could be made quicker and less chance of appeals being held through lack of or incorrect data being used.</p> <p>Home visits should always be an option.</p> <p>12) Where the evidence is clear that a condition is unlikely to improve or be cured then I would go for a 3 year interval. This fits in with the time period a motability car is available for example. A review then would confirm entitlement to a motability car. It avoids the situation I've seen happen to others where a DLA claim suddenly gets reviewed and they're asked to return the car only to win it all back on appeal. A waste of time and resources.</p> <p>If there's a condition that medically speaking could improve over time then an annual review would be pertinent. The usual rules apply anyway in that a claimant should inform of any material changes. Those who don't, should have the full weight of the law thrown at them for fraud.</p> <p>13) Simple, those who don't report changes are guilty of fraud. As such they should have the full weight of the law thrown at them. Judges need to impose severe sentences to act as a deterrent. I see benefits as a privilage, not a right and would have no compunction in reporting anyone I suspected of fraud. Spot checks, when the new system is up and running should be done periodically to ensure compliance. Penalties need to be made as clear and as simple as any new procedure for claimants.</p> <p>14) Applicants/claimants need, first and foremost, to be treated as human beings not as a number. They need to know what benefits they are entitled to, how to make the claim, what their responsibilities are, what information they need to supply and when. From the DWP side, they need to have access to all the relevant data prior to deciding a claim and that includes any medical reports from the claimants own doctors. Its not an easy task, we're all individuals, with differing needs but ultimately both 'sides' need to work together to get the best benefit for all concerned.</p> <p>?) Those of us with physiological conditions should have access to free prescriptions. This is based on my personal experience mentioned in other answers given here. I think there should be an automatic link to other services that may be of benefit whether that's from a</p>

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	<p>'one stop' advice centre or via doctors surgeries is open to debate.</p> <p>?) Assuming councils remain responsible for housing benefit then they should be notified automatically which should, in turn simplify claiming housing benefit. Prescription services should also be notified so again a layer of paper filling claiming help for prescriptions can be done away with.</p> <p>?) Please, please, don't treat us single folk as non-entity's. We may not need the amounts that a family or couple need but it is actually more expensive for single folk to live. Food for example, its packaged and aimed at families/couples, buying singly is more expensive.</p> <p>?) Based on my own experience the current system is flawed. The forms don't cater for my condition nor do the majority of questions asked at reviews.</p> <p>I have, prior to 2000 worked all my life, always been active in both work and leisure pursuits. I did both paid and voluntary work, enjoyed mountaineering, being a police special etc. I now suffer with Non-Operable heart disease, I struggle on a daily basis, I don't need added stress and hassle. My days vary from bad, very bad to just plain awful. I do battle with others who don't understand the condition I have. There's an attitude of ""you've 2 arms, 2 legs"" what's your problem? Not all disabilities are plain to see by others. Regardless of whether its govt depts, friends, family or other 'official bodies' the added stress of dealing with day to day issues just adds to my condition and makes it worse. Not being able to do things that I once took for granted is frustrating. I've always seen benefits, at any level, as being a privilage not a right and I appreciate what I get. Getting their is a minefield and the whole system will benefit from being simplified, of that there is no doubt. I would caution against going overboard and making this just another cost cutting exercise rather than dealing with the real needs of real people. Peoples medical conditions don't disappear overnight just because the countries in a mess financially and its always to easy to target those less well able to defend themselves. I'm more than happy to see sensible reform of the welfare system, certainly targeting help to those most in need. Those who have had a 'free ride' with backache, or mild depression for example should be well targeted. I don't think those with drink or illegal drug use should be on benefits, for me, they're not medical conditions, they're self-inflicted conditions that should get appropriate treatment to get them off the drink/drugs and back working. I worked hard for over 26years prior to my heart problems. When I first claimed for help I was appalled and shocked to see and hear what others were claiming for. reform, yes, definitely. Help those who are genuinely in need, to use a paraphrase, its time to sort the wheat from the chaff.</p> <p>17) Keep it simple.</p> <p>18) This area needs to be improved vastly. The current system is difficult to navigate and is too complex. Simplification is the key to success.</p> <p>19) Hardship Social Exclusion Poverty Decrease in well-being The At Risk become more At Risk &amp; become more isolated as a result.</p> <p>20) The information should be held on a database that can be accessed by all relevant departments. Too much information is duplicated which adds to costs incurred by DWP. This infuriates the customer (claimaint)as not only do they have to repeat information time and time again but it causes even more anxiety.</p> <p>21) No significant impact</p> <p>22) The benefits system overhaul is long overdue. As a customer I receive many duplicated letters which I would hate to think of how much money is wasted unnecessary through poor ineficiency by way of paper, postage stamps, ink and envelopes. I get bombarded with letters from different departments asking the same information. If each individual department communicated efficiently wth each other a lot of cash would be saved.</p>
ONLINE551	<p>3) paying for every day skills that not possible with ones own body....washing dressing eating etc etc etc</p> <p>4) why make this SO complicated???</p> <p>who is this helping.....not the disabled.</p> <p>5) based on care and mobility needs of the individual,</p> <p>6) washing dressing eating when you are disabled just the basics are very difficult and take most of the day just to survive</p>

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	<p>8) based on care and mobility needs,whatever make their lives easier to manage.  10) Disabled people are experts in what care they need to make their everyday living easier.  ask them.....not ATOS admin staff or a PC  12) dla is supposed to be for the disabled person to help them to make their lives easier.....PIP  you cant put a time limit as to wether an illness will get worse or better.  the government should support the disabled in there needs  13) MOST PEOPLE DO.  0.027% did not reported changes.  14) be helpful  make forms easier  interviews less stressful  not made to feel like SCUM by DWP people  16) they use their DLA  you suggest the use PIP  17) SUPPORT THE PARENTS, they support their children  ?) you changed the laws so only the high rate gets carers allowance</p>
ONLINE552	<p>1) As a disabled person myself, I have difficulties with transport-I cannot access public transport because of the area I live in, therefore a car or financial means of taking a taxi are essential. Other difficulties involve obtaining part-time employment which I can actually do and the reluctance of employers to take on employees with disabilities, when they have plenty of able-bodied applicants, given the high unemployment.  2) The facility to lease a Motability car, which I have found invaluable.  3) Transport costs, especially if taxis are needed.  Costs of aids e.g. bath and bed rails, and adaptations such as walk-in baths and showers, which seem to be priced out of the reach of the ordinary working-class family.  4) Two rates for both components may make the benefit easier to administer, as long as the lower rate is a decent amount, not like the lower rate now, which is too low compared with the higher rate. The mobility rate in particular needs to be higher, to meet the cost of taxis.  5) Some conditions by their nature are long-term and have no cure, e.g.rheumatoid arthritis. Although the sufferer may have 'good days' the condition is always there and is prone to flare up. The danger of continual assessment of such a condition is that at one interview the disabled person may seem very restricted, therefore entitled to a higher rate, but at the next review could be downrated because they are having a 'good period' How qualified will the interviewing official be to make a balanced judgement? On the other hand, by basing the claims on an individual's circumstances, more consideration could be given to the area in which a person lives and will probably have to continue to live because they cannot afford to move, not as at present, where this is ignored.  6) You need to look at what activities,types and hours of work the person was able to do before they became disabled, or in the case of a life-time disability in a younger person, what any other healthy person of a similar age and situation would be able to do, and compare that with what the person or their carer confirms that they are able to do. Remember that the person most able to confirm the extent of their abilities is the disabled person or their carer, not an independent healthworker or Government employee, who does not know the person - their knowledge is theoretical.The most important activities are looking after themselves in the home, being able to prepare and eat meals, getting out of the home to socialise with family and friends and work.  7) You need to look at the overall picture, which is something that there is room for on the existing application form. The assessor should not have strict guidelines, but needs to take a wider view over a longer period; you cannot give for a few months, then take away if the person appears better on the next review, as this would cause undue stress, a factor in exacerbating any long-term health problem.  8) I consider that this is a cruel proposal. The aids and adaptations are only there to help the disabled person cope with the basic tasks; they do not make the disability any more bearable and without them, the person would need far more financial help from the state i.e. institutional care. These aids should not, therefore, be taken account of in assessing the new benefit. Many of these aids and adaptations have to be paid for, given the financial burdens the local authorities are under, which many disabled people are unable to afford, being on low incomes.</p>

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	<p>9) Leave more of the form to be filled in in the person's own words, instead of having to answer pointless and sometimes ridiculous questions. There is bound to be negative content, as one is applying for a benefit because one cannot do certain things, but if the form is more narrative, the person could say, "I need this in order to help me to do this" e.g. hold down a job.</p> <p>You need nationwide publicity by means of leafletting. The leaflet needs to set the provisions down in clear, simple English, with no jargon.</p> <p>10) As stated previously, the best evidence should come from the disabled person themselves, or their carer. Obviously, a consultant's notes should also be considered i.e. length of time the person has been under their care, the treatment and any progress or otherwise. Many disabled people, myself included, do not bother their G.P.'s, preferring to wait to see their specialist and rely on the treatment given by them.</p> <p>11) Benefits: Many people find it easier to speak to a person face-to-face than write things down, especially where there are literacy problems or they have little or no sight.</p> <p>Difficulties: The cost of paying the many additional healthcare professionals will have to be off-set against the savings made by revising the benefit.</p> <p>It will be important for the professional to remain impartial and not jump to their own conclusions about a person's disabilities.</p> <p>Face-to-face interviews may be inappropriate where the person has a terminal illness or severe mental condition. In these circumstances, it is obvious that the higher rate is appropriate.</p> <p>12) If the condition has commenced fairly recently i.e. within the past 2 years, then the reviews could be set at 6 monthly intervals for another 2 years, depending on the type of condition; thereafter the reviews should be no more than annual, to avoid an untenable workload.</p> <p>All reviews should have the same format, but obviously each one will be geared to the abilities and circumstances of the customer.</p> <p>13) Anyone who is determined to defraud the DWP will not respond to 'encouragements' to report changes. However, by frequent reviews any fraud should be reduced.</p> <p>14) They need advice on obtaining aids such as bed rails, bath rails, kettle tippers, etc. They also need to know about the availability of other benefits/grants, which could be of help to them. The health professionals who interview them are well-placed to provide advice. They could be supplied with packs to give the customers at the time of the interview, which also include useful phone numbers.</p> <p>15) I consider that advice should be given as part of the interview but do not agree that penalties should be imposed if this advice is not acted on, as this could be construed as heavy-handed tactics and very unhelpful.</p> <p>16) When I first had rheumatoid arthritis, I was working for the DWP. An Occupational Therapist visited the office and measured me for a chair and other aids. She also referred me to Social Services, who gave me a kettle tipper (more trouble than it was worth, so I eventually had to buy a light kettle myself), a bed rail and bath rail. The bath rail is now rusty but I have to buy a replacement myself, which is quite expensive. After I retired from DWP, I had a 3 year fixed term job and Access To Work paid the cost of an office chair and other aids; they also helped with the cost of taxi fares, as I cannot drive all the time and my husband works shifts. Larger items such as a walk-in bath are beyond our financial means, so I will have to struggle.</p> <p>17) I do not feel qualified to comment on this question.</p> <p>18) I have found my DLA entitlement very useful in accessing the Blue Badge scheme, Access To Work and in particular the Motability scheme, as I could not do without my car, which, as it is new, I can rely on not to break down. Showing my entitlement letter has shortened the process of applying for the above and I consider that this should continue, given the difficulties disabled people already have with everyday matters.</p> <p>19) Motability, which is a brilliant organisation in helping disabled people would have to close down, causing great hardship to many disabled people. Accessing other services would involve long waits while doctor's letters were obtained and sent off. This again would cause hardship to disabled people and in many cases would result in their being confined to home unnecessarily.</p> <p>20) I would not mind my information being shared with my Local Authority, in order to speed up any requests for disabled services. I would not be in agreement, however, if such information were used to reduce any monetary benefits, given that the new benefit is meant to be non means-tested.</p>

Respondent Number	Response
	<p>21) The greatest impact will be on disabled people, many of whom, with chronic conditions, are already worried that the new rules could be used to reduce their benefits. You should therefore avoid taking too rigid a stance when developing the policy and be prepared to take a wider view.</p> <p>The next greatest impact could be on ethnic minorities, whose English is poor. If they have to have face-to-face interviews, they may need to pay to have interpreters present, if there are no local charities who can help.</p>
ONLINE553	<p>1) 1. The built environment, despite the DDA it is not possible for disabled people to lead an independent lifestyle for 100% of the time. As a wheelchair user, I cannot even get out of my street because there are no dropped kerbs on the footpaths meaning that if I did wish to push anywhere, I would have to do it on the very busy main road and put up with the risks of doing so.</p> <p>2. The transport system is not fully accessible, not all buses have lowered entrances for wheelchairs, for instance. If I want to take a train journey, I must book in advance and suffer the indignity of being pushed up a ramp onto the train. I am unable to get to the buffet car as the aisles are too narrow to get my very normal sized wheelchair down. If the carriage that holds the only wheelchair space isn't on the train, I have to wait for the next one and sometimes the next after that. If the loo in the carriage isn't working, I can't get into other carriages, again, because the aisles are too narrow. This curtails my ability to travel both for pleasure and for work purposes - I cannot be wholly independent.</p> <p>3. Aeroplane travel - as a paraplegic, I cannot stand and therefore cannot get into a plane toilet, therefore foreign travel is an absolute impossibility as is trying to travel within the UK by plane. In addition, airlines are very reluctant to allow a wheelchair user to travel independently, plus wheelchairs invariably get damaged whilst in the plane hold.</p> <p>4. Bad weather - during the long winter over late November and December, it was impossible for me to get out of the house and even push my way to get to my drive. I was totally isolated.</p> <p>5. Being active i.e. sport and leisure - despite the DDA I cannot find a gym or swimming pool that is accessible in my locality and again, I would always have to have someone with me - I cannot be independent.</p> <p>6. Ongoing therapies, particularly physiotherapy - impossible to access unless there is an ongoing problem.</p> <p>7. Work - employer attitudes are still about seeing a person's disability rather than ability - we all have a right to work and earn money which in turn opens up life to other things - why should disabled people live on benefits and in poverty.</p> <p>8. Other people's negative preconceptions of people with disabilities - why make adjustments to premises for access if they think that people with disabilities don't have a social life, that they stay at home all day and dribble!</p> <p>9. Finding a reliable and trustworthy carer is always an issue, there is high turnover in this profession, what happens if your carer doesn't come in one morning - do you stay in bed all day?</p> <p>10. General ability to carry out day to day tasks, cooking, cleaning, washing, ironing, doing the garden - all those things that others take for granted</p>
ONLINE554	<p>1) My main problem is that the DDA was almost completely ignored. How many restaurants and cafes have wheelchair accessible toilets? Who would patronise a hotel, pub or restaurant which had no customer toilet facilities? That is what happens frequently if you are in a wheelchair. Having more money will not help this situation.</p> <p>2) The motability scheme is essential for some of us. I cannot get to a bus stop or train station even if I could get on or off public transport. My motability car is my lifeline and preserves my sanity.</p> <p>3) home heating for those who are not active. some have to pay people to shop for them.</p>

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	<p>have to use a car for EVERY journey no matter how short.</p> <p>4) Obviously the former care component had two levels, day or night or 24 hours. This should remain.</p> <p>5) All claims should be based on the needs and circumstances of the individual</p> <p>7) Only by checking regularly except where it is obvious, like the loss of a vital limb. This will not change. These checks should be made with discretion as it can be insulting to ask someone who is obviously chronically disabled whether they have got better.</p> <p>8) any aids or adaptations incur difficulties. These should be assessed and age taken into consideration also.</p> <p>9) The form should explain that the benefit is not dependent on working. It is many years since I completed a form for DLA so I cannot remember if it is difficult. I understand there are always people who can help with its completion. This fact can be clearly stated on the form.</p> <p>10) Not a G.P. for obvious reasons. A health care specialist with the right knowledge could help.</p> <p>11) A one-to-one meeting for an assessment could cause embarrassment for the beneficiary especially in a claim regarding a mental problem but might be unavoidable to ensure the claim is genuine.</p> <p>12) There should certainly be different types of review depending on the needs of the individual and their impairment/condition.</p> <p>It is pretty obvious that some conditions are for life and reviewing these could be a waste of resources.</p> <p>13) This will be difficult to encourage as people will not want to give up their benefits. However, failure to disclose improvements should be heavily fined or result in having to pay back a portion of the benefit which has been awarded.</p> <p>14) I think it would be helpful to direct the potential beneficiary to advice and information they could apply for.</p> <p>15) It could be stated on the form that seeking such advice and support, will not necessarily impair their chance of claiming the benefit, but might well improve their chance to succeed in their claim.</p> <p>16) It could help some people to be able to apply for a one-off payment, but what would happen if their condition gets worse and they then need a regular payment later on?</p> <p>17) It would be essential to accept the changing needs of disabled children as they grow older on a very regular basis.</p> <p>18) It is important that DLA indicates to other resources that the beneficiary has genuine needs. Not sure of the answer to the second question.</p> <p>19) People could lose out on accessing other benefits and services.</p> <p>20) Combining different assessments for benefits and services could deter people from committing fraud and therefore be beneficial. However the fact that these facts are to be shared should be indicated to the beneficiary from the start.</p>
ONLINE555	<p>1)</p> <p>2) until am clear what changes are to be proposed , not sure.</p> <p>3) heating bills especially but water , gas and electricity all cost more as we are usually at home all day.. in a wheelchair we cannot warm up easily, everything takes us longer to do.</p> <p>transport, taxis often charge more for wheelchair people.toiletries (incontinence), more bedding needed etc fro same problem..help to do simple things like gardening..</p>
ONLINE556	<p>1) You have problems in using public transport, using buses, paying for taxis and the expense, of train travel. many disabled people have to have carers to help.The car is the only means of remaining independent</p> <p>In the working place many employers are still not disabled friendly, therefore not providing the right support and reasonable adjustments.</p> <p>day to day living is much more difficult, ie performing simple tasks which able bodied people take for granted.</p> <p>2) Under the current system Chronic Illnesses such as mine MS, mean there is no need to be continually assessed this should continue. Without subjecting people who are already suffering to further stress</p> <p>3) Travel costs, living costs at not being able to work. In many cases like mine being</p>

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	<p>unable to continue in the career for which I was trained.  Wheel chairs, mobility aids, car adaptations, increased holiday costs as most accomodation unsuitable therefore have to stay in more costly accomodation. Adaptions round the home, stair lifts, wider doorways etc</p> <p>4) I do not have a problem in understanding the benefit given to me now and understand the various levels of support.  Reading the different assessments which are about to start in this country does not help people with chronic conditions which are only going to get worse and not better. please think about progressive chronic illnesses which may one minute be not too bad and then in the next day is much worse,[this is the way MS and other neurological illnesses work] It doesn't matter about the different components one day I may need care and change during the next week, components are not going to cure us.</p> <p>5) I think if diagnosed with a certain illness it should mean an automatic benefit for one reason when one is diagnosed it is almost impossible to get jobs [the DDA doesn't mean anything it is a well known fact if the choice is a fit able person or one with a disease we know who people will chose leaving the disabled to struggle even more. The question is would people doing assessments be consultants or doctors who understand the different illnesses. "no"</p> <p>6) all everyday activities are very important for people to lead a full indepedent life so starting with getting out of bed, cleaning teeth to driving a car is all important.I find it impossible to prioritise because to each and everyone of us we all have very different requirements.</p> <p>7) You can only ensure assessments carried out are by proper medical people who understand the various illnessess otherwise it will be a total mess and many appeals costing more money.</p> <p>8) Wheelchairs ,crutches,mobility scooters,walking frames and sticks Other disabilities may take into account dogs who help care hearing aids etc. Car adaptations.  You should take into account the people may be eligible as well as those already who have adaptations.</p> <p>9) Not so many questions which repeat themselves mant times on the same form.Wording the questions more appropriately.  You could perhaps provide DVD for people to borrow explaing the form and questions or putting the information on the internet.</p> <p>3) The main costs are the travelling taxis,trains buses and if you are lucky enough to be able to drive affording a car.  Ths cost of adaptations around the home stair lifts extemson for bigger equipment.  the cost of aids wheelchairs, crutches, mobility scooters, sticks,and it maybe a dog as a carer and for some people carers.  Many people haven't got a job but they will need all the extras.</p> <p>2) I feel there is nothing badly wrong with the DLA I understand the way it works and I feel once you are awarded it with a long tem chronic progressive illnedd one should not have to go for continual assessments putting them through more stress.</p> <p>4) I have no problem understanding the current DLA and feel this new idea is going to cause more stress fo the already ill people. How can you possibly assess person with MS When the disease is so varied and it all depends on what time of day it is and may differ from one day to the next and knowing full well the assessors will not be trained medical people with an understandin of the different diseases let alone differnt components, this will cause alot of people to suffer.</p> <p>5) Yes some diseases such as Multiple Sclerosis and Parkinsons disease are a chronic progressive illness which means they WILL never get better.These people do not need the unnecessary stress which filling in forms and applying fot the DLA put them through. These people have often lost their careers they have trained for surely some support would be good at a time in their life when they need it. They already lost a salary through their illness.</p> <p>6) I find this question is difficult to answer how can you possibly prioritise people when everyone has differnt needs and in their own way are just as important.Every activity is essential right fromm cleaning their teeth, getting out of bed to driving and seeing people or even getting to work if you are lucky enough to have a job, most of us have a house to look after, children to care for or looking after ourselves with our disability.</p> <p>7) the people who are assessing people with a disability need to be medically trained ie doctors or consultants [who haven't got time to do their own jobs] who understand different</p>

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	<p>illnesses if they are unsure of the disabilities it will cause a lot of stress and uncertainty and cost a lot of money with the ever increasing appeals.</p> <p>8) The aids to be included are wheelchairs, crutches, walkers, scooters sticks and many more depending on your disability and where you are going to use them. Yes you should take into account certain adaptations as long as it does not disadvantage people if they don't use them, ie with fluctuating illnesses such as MS you may have to use a wheelchair one day but not the day that doesn't mean they are better just having a better time. You should consider people may be eligible at some point in their lives even though they do not need them at that time in their lives.</p> <p>9) You could make your form easier to understand and not keep repeating the questions ie try and make the form less daunting. You could perhaps try loaning or giving DVD's out explaining the different questions.</p> <p>The form filling is very negative and can be very depressing try wording the questions in a more positive way so people don't feel bad about themselves.</p> <p>10) Anyone who is being supported by medical professionals such as physiotherapists, nurses doctors etc However this is going to be a lot more paper work and they will not have the time or resources. They will need more time and money for this extra work</p> <p>11) The difficulty of having a face to face contact with a professional is that it may cause unnecessary stress which may exacerbate one's illness.</p> <p>The benefits are the healthcare professional will be able to see for themselves the actual disability but that does not mean in one half hour assessment they would actually see the true picture as many of the illnesses fluctuate.</p> <p>It would all depend on the disability whether it is appropriate to have a face to face meeting as I am sure it would not be necessary if their doctor or consultant has stated how disabled they are.</p>
ONLINE557	<p>17) Children may be more likely to be going through a period of diagnosis, and that some treatments cannot start until they are a certain age or capable of taking them.</p> <p>There may be educational impacts to their illness or disability. This may mean they don't attend school as regularly.</p> <p>That ability to take medication can vary with maturity rather than age, dosages to medication can vary with the severity of symptoms and children may not grasp this.</p> <p>10) Personally I find the DLA and PIPs systems poor for our circumstances. I have twin boys with a long term illness, that will progress, the illness is worse now than when they were younger, their prescription list runs to 16 items.</p> <p>We regularly have to travel to various hospitals and pay for parking and train fares to do this, they miss time at school because of it. They cannot go out to play at school in the summer or participate in PE. They have had no extra educational support.</p> <p>If due to the various rules we stop getting DLA or PIPs, how will we fund hospital trips? and once they are older how will they pay for the medication they need to keep them well, medication we are told they will always have to take? We are not talking 2-3 items here.</p> <p>It is hard enough trying to negotiate with various schools to have treatment plans in place, to be ever available if something goes wrong. It affects my ability to get a job as I have to work around them.</p> <p>If you do change this please make it fair, and recognise the real impact of living with a long term illness. It's not always about how far you can walk or what work you can do, it is exhausting dealing with that much medication, the various visits to the doctors and hospitals. A diagnosis isn't a badge of honour it's a lifetime of learning to live with your condition and its impact on your life.</p> <p>At the age of 10 we were told by a doctor this illness would rule out several types of job for our boys. At 10 years old they are already being restricted not by their ability but by their illness.</p> <p>Please make this fair for people like us.</p>
ONLINE558	<p>1) I have MS, use a wheelchair all the time, and am dependent on others for most aspects of daily life. Physical access is a huge problem (though the situation is improving); and the costs of care and necessary equipment (not all of which is available from local authorities facing cut-backs) can be prohibitive. To be accepted alongside the non-disabled population we need to be visible.</p> <p>5) Looking at the list in Annex 2, I cannot imagine how anyone with such a condition could</p>

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	<p>have 'personal independence' without incurring extra costs. It follows, therefore, that administration of the benefit will cost less if certain automatic entitlements are retained.</p> <p>?) The proposal to remove the mobility component of DLA from those in residential care does not square with the expressed intent of the benefit to support those least able to live full and active lives. Most of us would deem essential to everyday life not only activities such as eating, washing etc, but also the opportunity to take part in the whole society; if we restrict support too much, we may lose the right to regard ourselves as civilised, and deprive our society of the contributions of a significant number of citizens.</p>
ONLINE559	<p>1) Ill health - for many people the problem isn't simply problems/impairments. The problem is being too ill to get up/go out/participate normally. DLA certainly helps to facilitate this, but please do not under-estimate the fact that many people receiving it are unwell.</p> <p>2) 1)Yes. DLA is currently claimed by people over 65 if they were awarded it at an earlier point. Just because you are older, does not mean that your needs decrease - on the contrary, they are likely to increase. Please do not get rid of DLA for older people.</p> <p>2)The current system of assessing need on the basis of written information works well. The medical assessment for people on employment and support allowance does not. I see no reason to change the existing system. The benefit is already quite difficult to access and many people who seem to meet the criteria are turned down, as is evident from the success of reviews and appeals.I suggest you keep a paper based application rather than introducing what will undoubtedly be an expensive face-to-face assessment aswell.</p> <p>3)I understand that the government aims to save 20% costs with these reforms. Having a target such as this is incompatible with a benefit which is supposed to be based on individual needs. I suggest you drop the target.</p> <p>3) Domestic help - with cleaning, cooking etc. shopping, transport, help with computers and admin, assistance to get about, help with garden maintenance, help using public transport, heating, special diets,</p> <p>4) 1)It may make things simpler</p> <p>2)Three rates of care would be more accurately targeted to people's needs unless carefully calibrated the reduction to two rates will very likely reduce financial support to those with the highest care needs.</p> <p>5) I am uncertain about this but think that on balance, some automatic entitlements should remain. In particular, if people have had an automatic entitlement on this basis, this should not be removed when the new benefit is introduced to these individuals.</p> <p>6) If people are employing carers themselves, under direct payments, as will be increasingly common, they will not simply be able to stop paying workers with whom they have contracts because they are in hospital or temporarily in a care home. Benefits should continue to be paid for them in these circumstances.</p> <p>7) This is extremely important. If people have variable or fluctuating conditions, they must be able to be honest about this without jeopardising receipt of benefits. The application form and medical assessment need to be aware that many conditions do fluctuate and officers making judgements must be trained to make these assessments.</p> <p>10) evidence from GP, hospital consultants, physios, OTs as appropriate</p> <p>11) 1) If the individual is already in receipt of benefit and there is little likelihood of their condition improving</p> <p>2)The medical assessments for E and SA are not fit for purpose. These should be used as a template for how not to assess and treat recipients.</p> <p>12) It should all depend upon the likelihood that an individual's condition might improve/deteriorate. Ongoing unnecessary reviews are extremely depressing for claimants and an unnecessary use of scarce resources.</p> <p>13) By asking them</p> <p>14) probably</p> <p>16) possibly</p>
ONLINE560	<p>1) My brother has autism he cannot live independently as he cannot organise himself, cook, tie his shoe laces etc Active lives imply a social life Autism is a SOCIAL disability which is invariably associated with other complications. When he tries to interact with other people they become aggressive and frustrated with him because they do not understand</p>

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	<p>and thus he retreats even further from society.</p> <p>5) The medical assessments concern me. My brother has autism, he will ALWAYS have autism. There is no cure, I cannot get any medical help, my doctor refuses to refer my brother to a psychologist and just wants to put him on anti-anxiety pills. Surely in cases such as autism when the condition is life long has no hope of improvement (particularly in our case when he was not diagnosed till in his 30's and by then too late to affect his behaviour) once diagnosed the medical assessments should stop and the entitlement becomes automatic. I cannot tell you of the level of stress and anxiety my brother goes through with these assessments- not to mention my own - he was suicidal last time.</p>
ONLINE561	<p>3) As a wheelchair user:</p> <p>Personal Care: Getting up, showering, dressing,preparing to go outside,going to bed. Changing catheter.</p> <p>Transport eg £16800.00 adapted secondhand car (purchased 2005): £6700.00 Wheelchair (2007)</p> <p>Adaptations to house: Rolling programme;eg ensuite wetroom, lowered thresholds, modifications to garage and paths round house.</p> <p>(Kitchen next on list)</p> <p>Aids to carry out day to day tasks; eg door entry system to speak to and admit visitors. Opening windows.</p> <p>Heating costs</p> <p>Food - I need help with preparation &amp; cooking therefore tend to buy more ready prepared meals rather than start from basics eg vegetables bought ready prepared which are more expensive.</p> <p>Extra Clothing to keep warm; elbows wear out very quickly in a wheelchair. ( Cost saving on shoes!)</p> <p>Heating costs.</p> <p>Communication system costs to call for help in emergency</p> <p>5) No automatic entitlement. Needs of applicant to apply.</p> <p>6) Care, so that recipiant can lead a safe &amp; healthy life is most important.</p> <p>10) GP and medical history plus home visit. Care evidence can be supplied by applicant. Interviewers need to be able to look round house and applicants should be aware of this; and they might be asked to move about. I have had Social service assessors who sit at the dining room table discussing getting me up and putting to bed and have never asked to see the bedroom! (How can they be said to have made an assessment of the situation? Huge waste of public funds.)</p> <p>12) More frequent reviews if the condition is likely to change. eg degenerative condition (get worse) injury (improve or general health and therefore capability improve)</p> <p>See also Answer 7</p> <p>13) Send them a form to report any changes periodically. Suspend payment if no response. Have randon reassessments. Prosecute those who cheat.</p> <p>14) Guide as to who qualifies and what the benefit is for; also what the responsibility of the claimant is. eg being assessed to drive car and what modifications are needed, if they are claiming mobility problems. Include this with application form.</p> <p>16) See Answer 8</p> <p>17) They need to be assessed more frequently as their needs change more rapidly.</p> <p>18) It is often used as a shortcut to entitlement eg warm front. However very often these are items that DLA could be intended to cover.</p> <p>?) Some would take it up, some would not. People with disabilities vary across the spectrum the same as anyone else. Perhaps a grant of 50% would be an economy for the</p>

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	<p>public purse but encourage people to take up the offer.</p> <p>20) No comment on combining allowances All government agencies should share information to cut down on bureaucracy (see also previous answer re driving ability)</p> <p>21) Shouldn't have any impact but procedure should comply with the Recent Equality Act. Policy should be proactive.</p> <p>?) The media are generating more heat than light over this. You will need to explain it carefully. An information sheet or direction to a website to recipients of DLA might help. Publish / use Access to work more to get people back to work. Do away with the £10 bonus, it must cost more to administer than £10. Roll it into all benefits at their next adjustment.</p> <p>1) Information on access to services &amp; buildings; what services are available to enable access to all; eg Is the next bus accessible to a wheelchair user? There is no information at the bus stop - when you phone the bus company they don't know. Attitude of Social Services who spend more budget on administration &amp; information gathering than practical help, enabling people to live independent lives.</p> <p>2) Where recipients are in Residential Homes and transport costs to social / educational / medical events are not included in the fees, mobility allowance should be paid.</p> <p>4) Probably easier to administer but fairness may not be easier to understand.</p> <p>7) Make it a requirement that the recipient fills in a form periodically detailing their needs in relation to their condition. If we don't respond within a given time suspend benefit. Some recipients could get a random assessment visit.</p> <p>8) Not necessarily - if they are paying for them using DLA they should not be penalised. Aids provided by the state take a long time to obtain; professionals are ill informed about what is available; they don't attend exhibitions and keep up to date with latest developments: they work from a list that hasn't been reviewed for many years; they often can only obtain items from one supplier who has no competition and therefore no incentive to provide a good competitive service. There are limited finances in the public purse to provide training or the aids; it seems reasonable that recipients should get free advice but pay for aids themselves from DLA. This would make items cheaper as the competition would be greater and only aids that were useful and genuinely needed would be purchased.</p> <p>9) Don't worry about the form. Every agency and their brother is anxious to assist in claiming benefit. Ask all the questions you like. Also link up your departments; why are you allowing people, who claim they have mobility problems, to drive around in unadapted cars? Anyone who claims to have a mobility problem should automatically give up their driving license until they can show they have been assessed and have their license endorsed to show what adaptations they need on any car they drive. Send an explanatory leaflet next time you communicate with them; eg on notification of change in amount of payment.</p> <p>11) See above; plus possibly include applicant's OT or other health professional. Possibly terminal illness where consultant &amp; health professional think it is not needed and to facilitate speedy award.</p> <p>15) The question doesn't make sense - how can you have a 'requirement to advice and support'? You could have a right to them, not a requirement.</p>
ONLINE562	<p>1) The disabled have many barriers, including Lack of funds and understanding from able people. Why are you taking us back to the Dark Ages this is 2011.</p> <p>2) The DLA is not broken so there is no need to change it.</p> <p>3) Cost are rising every day increases in power, communication, transport and daily requirements like food even the need to belong to society is costing more. Care Mobility Communication Insurances We are all humans and entitle to a full life.</p> <p>4) The World of the Disabled Person is far too complex to have just two criteria. How long does it take for Doctors to qualify in and specialize in these areas how many departments are there in Hospitals. What is being considered here is to totally ignore what the specialists who are qualified in these different fields say about the disabled person which is totally vain of Government to assume they know better.</p>

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	<p>5) The Disabled are Disabled  6) Reduce their outgoings  Respect them  Care for them  Love the them  7) By seeking advice from the Qualified Specialists looking after the individual  9) Obtain a written report from the Qualified Consultant who specializes in the area of the Diasibility to provide a written notice of the disability and accept his conclusions.  10) The individuals Qualified Consultants report is all that is needed.  11) Perhaps you could appoint a Qualified Social Worker to sit in on a meeting with the Qualified Consultant of the individual and the individual, so as to understand a bit more about their disability.  But if you have the individuals Qualified Consultants report surely that is all that is needed.  12) This would depend on the Qualified Consultants reviews.  13) Listen to the individuals Consultant  ?) The process should be simple enough ask the individuals consultant the question.  ?) The allowance should be made available to all disabled people.  The support network should be left to qualified practitioners.  ?) No  the adaptations should come from the NHS in relationship with the individuals Qualified Consultants recommendations.  The disabled should not have to incur further costs  ?) Listen to the Qualified Consultants  ?) Please stop this desire you seem to have to torture and break the disabled.  ?) The DLA works perhaps the only improvement would be to listen to Listen to the Qualified Consultants.  ?) Listen to the Qualified Consultants.  ?) You are going to make more people discriminate against the disabled.  Even the disabled will start to discriminate against each other.  You will take all independence away from the disabled  You are about to turn the clock back to the days when the disabled were seen as freaks.  ?) Please reach into your hearts and stop hurting the poor.  You are about to turn the clock back to the days when the disabled were seen as freaks  Reevaluate yourselves why are you targeting the disabled are they not worthy.  Remember these people, so delicate whatever their disability is.  Also it is by the grace of God you don't have these problems.  8) All adaptations should be excluded  As to what adaptations the Qualified Specialist in the particular field would be able to assess this is not the unqualified.  It is part of the Disabled person s burden, it also makes a visual statement.</p>
ONLINE563	<p>5) Those diagnosed with 'Multiple Sclerosis' should have an automatic entitlement to the benefit.</p>
ONLINE564	<p>?) The Government propose to remove the mobility component of DLA for care home residents from October 2012. Therefore PIP would similarly not be available to these people. I believe it is wrong to compare disabled people in care homes with people admitted to hospital. They are not ill. They are resident in care homes because they cannot look after themselves and their parents are no longer able to care for them properly. There is no intrinsic difference between disabled people in their own homes and those in care homes, the differences are those of individual need and circumstances. Therefore it is illogical and unfair to deny disabled residents of care homes the right to apply for mobility assistance as would be available to a person living in their own home. The extent, if any, to which local authority funding meets an individual's independent mobility needs can be taken account of during an assessment for the Personal Independence Payment.</p> <p>I give as evidence the following information regarding my son [REDACTED]. His residence is: [REDACTED], [REDACTED] Road, [REDACTED], [REDACTED], [REDACTED].</p> <p>My son [REDACTED] is aged 29, is severely learning disabled with a mental age of 2 years, and is autistic. He is physically fit and active and leads a happy life under the excellent care he receives at the care home he shares with 23 other severely disabled people in [REDACTED].</p>

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	<p>█████, █████, near █████ was purpose built in 1999 and comprises 4 bungalows each with 6 residents. Each bungalow has a vehicle to provide transport for group activities. In addition nine residents use their mobility DLA allowance ( £49.85 per week) to lease a vehicle through the Motability scheme. █████ is one of these.</p> <p>Because of █████ severe learning disability his ability to communicate is very limited, he has no understanding of danger and his behaviour is often challenging. Caring for █████ is therefore extremely hard work for all involved. Having a vehicle available for his own use is essential in planning activities to meet his needs. Without his own vehicle he would be unable to access most of the activities that get him out of the confines of the bungalow: walks in the countryside, swimming, pub and cafe visits, plus days out to the seaside, zoo or Sherwood Forest to ride his bike in safety.</p> <p>The fact that the Motability scheme provides 9 additional vehicles gives staff flexibility in planning activities and coping with issues that inevitably arise with residents who have complex needs and challenging behaviours. The manager of █████ has said the effect of removing the mobility component of disability living allowance would be €œseverely detrimental €□ to the service and █████ bungalow manager told me she cannot begin to think what life will be like if these vehicles are lost.</p> <p>█████ has had a Motability vehicle since around 1996. █████ assessment for mobility allowance was For Life due to the fact there is no prospect of his condition ever improving. █████ is so attached to his own vehicle that he refuses to use any other. He is very accustomed to a regular routine of journeys in his vehicle. Without this routine of varied activities he will suffer anxiety and distress at being confined to his bungalow.</p> <p>This issue goes to the heart of what it means to be a civilised society and Parliament, when it is fully aware of the consequences of this measure, will reject it. Therefore the government should withdraw this particular proposal from the plans to reform DLA.</p>
ONLINE565	<p>1) Sadly the main barrier of people with disabilities leading independent and active lives is their disability and how much money they have to live on. It would appear this government has no intention of making the lives of disabled people any better but to make them worse by trying to force them into work when they can not and removing the small amounts of benefit they already receive forcing them further into poverty. The UK already has the strictest benefit criteria in Europe and it would appear this government is determined to make them even harder to qualify. How many people will commit suicide because the people the government pay to assess them fail them as not meeting the criteria and they are forced onto Job Seekers allowance when in reality they can not work. It is this government that is creating the barriers to disabled people leading independent full active and happy lives.</p> <p>2) DLA is a benefit paid to people who have a disability and or long term health condition. It is hard to claim and the rates of benefit are low. The Conservative/ Liberal alliance are trying to make the qualifying conditions harder and pay lower benefit rates. DLA should stay as it is unless a new progressive way of paying disabled benefit can be found.</p> <p>3) transport, shopping, care needs, accessing the community, leisure activities, social activities, Everything in life has a cost that can be applied to it. How is the Government going to put a price to these costs. How will those costs be transferred to a benefit rate.</p> <p>Just because someone can walk does not mean they are not disabled. Some people can walk well but are in chronic pain. It can be argued that if the right pain relief can be found then the pain would be removed and the person would not be disabled however what about the side effects of the pain medication will these also be fully included in the paid for assessment by people working for the DWP?</p> <p>4) Having 2 rates will change the criteria for each component and this government will use it as an excuse to prevent people being paid the benefit not enable people to access and qualify for the benefit.</p> <p>5) Yes some conditions should receive automatic awards and this should be made wider. Some personal circumstances should also be taken into account as should earning and or savings and residency in the UK or Europe</p>

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	<p>6) everyday life includes personal care, accessing the toilet, shopping, preparing meals. Everyday life also includes access to the community and social interaction with others. It would be very damaging to people with disabilities to focus benefit just on practical needs and not include social needs. A person may be able to makes meals one day but not others, or if they take medication and this affects them- it is important to make this person specific- that they then become unable to make meals. How can the effects of medication be assessed on an individual</p> <p>7) Why are people allready on DLA going to have to reapply and be re assessed. This is discrmination to disabled people as once again the purpose of this re assessment is to prevent people from claiming the benefit or reduce the amount they recive. Why is the Government trying to force people with disabilities into work when they reality is they are unable to or unable to for any long term period. Trying to promote work as equality of opportunity it is not an option for most people who have a disability intodays workplace. Companys do not meet there quota of disabled people in the workplace and those people with disabilities that do are often trophys for companys to say they are meeting goverment targets or for other quodos associated with discrmination. DLA PIP is dilbertley hard to claim and this goverment is intending to make it harder. The DWP do not promote it which means that it is under claimed so the proportion based on sexual orientation, gender etc and wrong. Many people go without rather than claim their legitamate right to benefit.</p> <p>8) The use of aids and adaptations only help a disabled person they do not stop the disability they should therefore be ignored. It is important to mention that an indivdual should not have there right to privacy removed by the assessments and that they are not made to perform.</p> <p>9) The criteria for DLA is open to intepretation and this is what is needed when dealing with disability as it is person specific. To define the criteria further will make it less open to interpretation and therefore fewer people will qualify which after all is what this goverment is trying to achieve. This is not progrssive. Applying for benefit on the UK is not a positive experience and European models value the person much more than any conservtive reform ever could.</p> <p>10) A personal statement from the individual applying for the benefit and how their disability affects them. If needed help should be made available for people who can not do this themselves. A GP or speclaist statment could also be used but this has to be based upon the indivduals experience not a simple one line response that may cofirm that someone has an illness but not how it affects them in reality or taking into account the medication and its effects.</p> <p>11) Carrying out a meeting in a persons home is an invasion of privacy and would not occur in other walks of life. Obviously a persons ability to travel or access a building should be taken into account. What is a health care proffesional, a nures understanding is differnt to a doctors and this is differnt to a support workers interprtation. Bearing in mind a health care proffesional is paid by the DWP how impartial is their opinion. People being assessed should always have someone with them so an impartial witness is avaiible as Health Care professionals often change their opion as required. Even attending a meeting is wrong why can this not be decided by evidence from a personal statement from the person their friends or family and a GP and or Specalaist/ Consultant. This is not a cost cutting exercise it is an exercise in gatekeeping which is illegal.</p> <p>12) From what I have read above fraud is what is implied in reading the text. Once again this goverment belives all people with disabilities and or long term health condtions that cause daily living problems and claim benefit are committing fraud. This is not the case. Any system can be abused look at MP's expenses scandal. Who checks on what Mr Clegg spends? I appreciate that since people recive benefit periodic reviews should happen but this should be dependent on the persons illness or disability and weather this is likely to improve over time. This could be done via letters. personal statements, GP/ Specalsits letter. The criteria should be open and not specific as people and health problems vary.</p> <p>13) People whos health improves should report this to the DWP this is something that people on DLA allready now. Benefit fraud does happen but fraud happens in all walks of life. All of disabled benefit litrature tells people to report changes.</p>

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	<p>The best way to encourage people to report changes is to make it easy for them to do and for other help to be provided in the form of job centre help, course for people returning to work and jobs that pay more than the minimum wage and are not in retail.</p> <p>14) It would be of great benefit to signpost people to other services. It would also be a step backwards to make this a condition of benefit. Who tells Teresa May what she can spend her money on? Once again people who have a disability are made to jump through hoops for the small amount of benefit they get. People who have a disability have the right to manage their condition as they see fit and this should not be linked to benefit sanctions. Perhaps putting more money into the NHS, Charities and housing would also benefit people with Disabilities.</p> <p>The use of government influence over large companies would also help. For example social tariffs for services would be a step forward if they provide real benefits for people.</p> <p>15) This is just a benefit sanction and of no help whatsoever. People have the right to self determine even if they claim benefit. People can only be advised not made to do things or that is not a free country or maybe it is not free to people who are disabled.</p> <p>17) Children with disabilities should be given every form of support available from housing to health care and benefits which reflect the true cost of their needs. Also they should not be abandoned when they reach 16 or 18 it should be seamless service the proposed benefit reform aims to prevent rather than enable.</p> <p>18) Most of the access to other services only apply to the higher rates of DLA. This should be available to people on any rate of DLA. People on the lower rates often cannot access the community or social activities and since these would have VAT applied the Government would recoup most of the money and social exclusion would lessen.</p> <p>Why will existing claimants be required to re-apply or be reassessed they already have been seen as being in need of DLA. This is another attempt by the current Government to prevent people claiming benefit and another way of the state seeing people on benefit as committing fraud. No where else would this apply and this should not happen.</p> <p>19) The real rate of benefit would be eroded causing lost people, social exclusion and poverty. Disabled people are not wealthy the majority receive small amounts of additional income and without those passports more benefit would be needed to offset the cost.</p> <p>20) There is much duplication and many assessments that do not need to be done and this is another example of how people on benefit have to perform and have their privacy invaded.</p> <p>The other side is that different assessments use different criteria and therefore can be of benefit.</p> <p>Why not pay people a social wage that includes all the benefits they are entitled to directly to the person.</p>
ONLINE566	<p>1) Lack of money, lack of jobs for everyone not just the disabled, societies lack of acceptance particularly of those with a learning disability</p> <p>2) it should stay as it is every civilised society should look after its disabled</p> <p>3) The cost of home care is high, the last government's 'Fairer Charging Guidelines' did not consider the needs of those with a learning disability - being innumerate makes budgeting very difficult - support workers are often poorly educated and trained and not able to assist those with complex learning problems</p>
ONLINE567	<p>1) The majority of 'disabled' people who receive DLA are restricted from leading a normal life and the payment of DLA [or soon to be PIP] enables them to partake as much as possible in the society around them</p> <p>2) If recipients are over retirement age then it is unlikely that there will be any improvement in their conditions. Carrying out reviews as a matter of course can only cause extreme distress and could be reduced as the recipient's age increases</p> <p>3) Laundry, heating, transport and medical care</p> <p>4) yes two rates are as good as three and two the most important thing being that they are applied fairly to all</p> <p>5) yes but individual needs must be considered for example a double amputee should automatically qualify for the higher mobility component</p> <p>6) Adopt a fairer assessment system NOT using the likes of ATOS medicals who anecdotally are accused of being biased against applicants and incentivised to provide results to ensure applicants are turned down. Take more notice of GPs and Consultants instead.</p> <p>7) By adopting a fairer assessment system NOT using the likes of ATOS medicals who</p>

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	<p>anecdotally are accused of being biased against applicants and incentivised to provide results to ensure applicants are turned down. Take more notice of GPs and Consultants reports instead of ATOS medicals.</p> <p>8) The ability to use aids or adaptations should not reduce the applicants chance of being awarded DLA [PIP]. The disability is there despite the aids or adaptations and that is what the assessment should be based on.</p> <p>9) Adapt the forms to reflect that not everyone is fully literate and with less trick questions. Simplify the forms and encourage the decision makers to adopt a policy where applicants qualify automatically unless they demonstrate that they do not qualify rather than the system is at present where the converse applies. Perhaps provide a form filling service for all</p> <p>10) the applicants GP and Consultants NOT the ATOS doctors who anecdotally are accused of being biased against applicants and incentivised to provide results to ensure applicants are turned down. Take more notice of GPs and Consultants instead.</p> <p>11) The use of face to face assessments are very appropriate and are better in the applicants home rather than a medical centre, but by the applicants GPs and Consultants NOT the ATOS who anecdotally are accused of being biased against applicants and incentivised to provide results to ensure applicants are turned down. Take more notice of GPs and Consultants instead.</p> <p>12) The same evidence and criteria that ensured the award was made initially should be used however different reviews should be dependent on need but in general over 65s should not be reviewed as they are unlikely to get better.</p> <p>13) By asking GPs to submit regular reports and by decriminalising the system so that recipients can contact the department for advice or guidance without the fear of breaking the law or having the award removed until they can prove that they still qualify</p> <p>14) The type of advice and information should be such that the recipients are able to easily access the information and advice required to complete the form or assessment to qualify for the award. It would be beneficial to all if a conduit to obtain help and advice could be set up outside the remit of the DWP perhaps similar to the Disability Helpline.</p> <p>15) Yes the type of advice and information should be such that the recipients are able to easily access the information and advice required to complete the form or assessment to qualify for the award. It would be beneficial to all if a conduit to obtain help and advice could be set up outside the remit of the DWP perhaps similar to the Disability helpline this would be able to ensure that those who qualify get the award and those that do not are turned down.</p> <p>16) Some people buy their own aids and adaptations as they are often unaware of what is available through the Local Authority or the NHS. How PIP is used is up to the individual.</p> <p>17) whether or not their condition is likely to improve as they grow older.</p> <p>18) It is working as it is so do not change it</p> <p>19) It would cause a lot of problems and cost a lot of money as each other benefit would have to then be assessed separately.</p> <p>20) There is no reason not to share all information so that it reduces the costs and to ensure that claimants receive what they are entitled to easily.</p>
ONLINE568	<p>1) I am a full-time carer for my disabled partner. There are various barriers, depending on the unique circumstances of each individual. Commonly, these may include logistical/physical barriers where the individual is housebound or requires a carer to accompany them, financial barriers where the individual is reliant on benefits because there is no realistic prospect of employment, social attitudes, and difficulties associated with mental handicaps, among other things.</p> <p>2) Claimants should continue to be able to allocate the benefit in the way that most suits their individual needs.</p> <p>3) Again, extra costs are highly variable depending on the individual circumstances. These include the cost of in and out of hours care (regardless of whether it's provided by a family member or outside agency), purchase/rental/maintenance of equipment or aids where these are not readily available via the NHS (e.g. walking frames, special beds, stair lifts, wheelchairs, hoists, adapted vehicles etc), assistance with travel and mobility (e.g. taxis if public transport is not suitable), among other things.</p> <p>4) I agree that because there are different levels of assistance required there should be different rates. The difficulty comes in trying to pigeon-hole each claimant into only one of two rates. I feel that this will often result in people not receiving enough assistance because they aren't considered quite disabled enough for the single upper rate, even</p>

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	<p>though their disabilities may be considerable. I would suggest that three rates for each component is probably the minimum required to strike a fair balance.</p> <p>5) I feel each claimant's circumstances should be considered on an individual basis. While the assessment needs to be consistent, it should not simply take the form of a long yes/no checklist -- a black or white approach to certain conditions. This does little to record an accurate picture, and would be easy for false claimants to circumvent if they knew the answers they needed to give to attain a positive outcome. Where the disability is clearly profound, however, there is little value in asking obvious questions.</p> <p>6) Depending on individual circumstances, essential activities include:</p> <ul style="list-style-type: none"> <li>- any required care/assistance with day-to-day tasks such as dressing, washing, feeding, personal hygiene, using the toilet, sitting down/getting up/laying down/changing positions where, for example, stopping in one position for any length of time becomes extremely uncomfortable due to disability.</li> <li>- cooking, preparing food and drink, or assisting the individual to do so for themselves.</li> <li>- general housework such as cleaning, if required.</li> <li>- help with dealing with claims, paperwork, and general finances for those who struggle to manage this themselves.</li> <li>- Mobility, e.g. helping the individual to get out of the home to go shopping, and attend appointments. Planning and arranging for these trips where needed.</li> <li>- some degree of social interaction for those who are completely isolated and/or housebound.</li> <li>- provision of anything that supplies a minimum level of mental stimulus for the more severely disabled. For instance, it should not be unreasonable for a person who is housebound to expect to be able to afford basic cable television services out of their budget if this is the only form of stimulus available to them.</li> </ul> <p>7) I would suggest that the claimant's GP would be well-placed to help with this -- they often have a chance to see the claimant over a period of time and have a better understanding of when assistance is needed, as well as any patterns of disability. The new allowance process must recognise that the prospects of employment are slim for most people who experience regular, but fluctuating disability. Few employers can accommodate workers who are off for extended periods at random. Perhaps a government scheme could be initiated that would offer people in this situation work at times when they are able by (for example) taking on clerical/admin, public sector work that could be done from home at any given time.</p> <p>8) I feel that aids and adaptations should rarely be taken into account because they rarely mitigate all problems. This is something not always obvious to those without disabilities. For instance, a person who needs a wheelchair to get around is still at a great disadvantage compared to an able-bodied person, and cannot truly be considered mobile . They still need to move from the chair to go to the toilet or perform other functions. They are still limited with regard to some access and many public transport services. They are also limited by the functions of the chair, the person who pushes it, or their own ability to propel it. While it could be said that the chair gives them some mobility, factoring it in on benefit assessment could lead to people's real needs being side-stepped, and would make the claimant entirely dependant on the chair (to achieve what the assessment expects of them).</p> <p>9) The way to make the application process more positive would be to take a more individual and 'human' approach--not to see the application as a series of yes/no questions that may do little to record an accurate picture. For example, a claimant may physically be able to pick a pen up off the floor, but if this causes extreme pain would that be a 'yes' it can be done, or a 'no'? Also, while it is great to focus on what people can do, this should not in any way detract from recognising what they cannot, and providing appropriate financial assistance.</p> <p>10) As mentioned, I feel that the claimant's GP would be ideally-placed to provide evidence, along with any specialists that may have been consulted (the onus being on DWP rather than the claimant to seek this evidence). Having seen the claimant over time, the GP will usually have a much better picture of the claimant's needs, and how their condition varies, if it does. I think this would also help greatly in detecting false claims since people with significant disabilities are likely to have</p>

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	<p>seen their doctor at regular intervals concerning their condition, or for medication/referrals.</p> <p>11) I think a face-to-face discussion, conducted at the claimant's home, would be a very useful part of the process.</p> <p>As well as offering a more individual and personal assessment of the claimant's day-to-day life, the healthcare professional may be able to suggest extra support or aids to make the home environment more suitable (e.g. handrails, frames etc).</p> <p>12) As before, I would suggest evidence should be given by the claimant's GP for reviews. This would help to assess any changes over time, such as further consultations, treatments, changes in medication, and so on.</p> <p>Review frequency should depend on the disability and history of the claimant. For instance, it would be a waste of resources (and put unnecessary stress on the claimant) to review the case of a profoundly disabled person who is already receiving the highest rate of assistance, and who clearly has no prospect of recovery.</p> <p>13) The best way to ensure that people report changes is to make the process quick, specific, and easy to understand. Currently, it seems as though there are different criteria for different benefits, and this can be confusing. Also, whereas major changes of circumstances are generally obvious, there are grey areas regarding what constitutes a (minor) change.</p> <p>14) At the time of making a claim, people should be advised of all other relevant support (e.g. via an info pack). This could include information about assessments for disability aids via the NHS, other benefits and one-off allowances, eligibility for any training schemes that might offer new skills (e.g. free Open University courses). Currently, things seem fragmented between different departments and areas, and should be more 'joined up' for the sake of the claimant and general process efficiency.</p> <p>15) A requirement to access advice and support might be useful for claimants who intentionally avoid improving their situation (e.g. to prolong their benefit claim). However, this should be limited strictly to those who are reasonably suspected of 'playing the system', and are refusing something that provides an obvious, risk-free solution. An example of this might be people with drug and alcohol addictions offered genuine and manageable rehab and support to get off their addictions.</p> <p>In general, disabled people face many challenges in day-to-day life, and any mandatory schemes, if applied for ALL claimants, risk further diminishing their independence and self-worth. It would therefore need to be handled very sensitively indeed, and made a requirement only in exceptional cases.</p> <p>16) Funding for aids and adaptations might come either from income or benefits, or may be supplied via the NHS, depending on the situation. It would be useful to have a facility for one-off payments for large expenses for things that cannot be supplied via the NHS and where there is an urgent need. This should not however come at the expense of losing some mobility/care benefit, and it should be means-tested to ensure that any large one-off payments go only to those who cannot comfortably meet the cost themselves.</p> <p>18) Wherever possible, a single assessment/benefit award should be used as a passport to others. This saves on multiple applications, inconsistencies, wasted resources, and duplicated effort. Please also see response to next question on this matter.</p> <p>19) Failure to use the Personal Independence Payment effectively as a passport, would result in multiple applications, inconsistencies, wasted resources, and duplicated effort at a time when cost savings are required. I imagine that it would also make cases of fraud more difficult to detect.</p> <p>20) There should be a single disability assessment for all disability benefits. While this single assessment would probably need to be more individualised and conducted in greater depth, it would be far more efficient and transparent than separate assessments and processes.</p> <p>Provided the standard Data Protection rules are applied, there should be no issue with holding a central file of relevant information to be shared by all official agencies. It seems to me that having this central file, which should include any (but only) medical history pertaining to disability claims, would also improve the chances of detecting fraudulent claims.</p> <p>21) I am not aware of any likely impacts on the equality groups, provided that assessments are undertaken by professionals without bias or particular objections, for instance on religious or moral grounds.</p> <p>?) I agree that it is essential that claimants can choose how to allocate their benefit income, as this is key to independence. I believe that, for many, DLA is fundamental in helping to</p>

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	<p>meet basic living costs. Without this, they would require other income support. However, disability benefits should be means-tested. Any reduction at all in payments to those people on low incomes will never be considered fair so long as assistance is automatically paid to those who are well off enough not to need it.</p> <p>?) Unsure.</p> <p>?) If the key aims of the reform include reducing costs and ensuring that help goes to those who need it, then means testing helps address both requirements. I would suggest setting a high level so that it allows (and encourages) people to save and be financially independent, particularly in provision for old age. However, claimants who have substantial savings (e.g. in excess of £100,000), have valuable non-essential assets, or have an income without benefits that exceeds the national average, simply do not need public assistance.</p> <p>There is growing concern regarding disability benefit reforms, both of DLA and ESA. Talk of enabling people may be perceived as simply cutting support €” setting the bar so high for qualification that many will be denied help. Denying or reducing support for a moderately disabled person whose condition makes employment unrealistic (even if theoretically possible) would be further disabling, rather than enabling. It would also create serious problems affecting all sections of society, and businesses, and ultimately prove far more costly to address.</p> <p>The system needs reform. But DLA is fundamental in meeting basic living costs for many who are vulnerable and already in greatly reduced circumstances. It is part of a fundamental duty of care.</p>
ONLINE569	<p>?) It would be dire, unless safeguards are put in place to ensure that no disabled person who needs those benefits and services is not deprived by bureaucratic structures. A realistic independent appeal system would be needed to provide such safeguards</p> <ol style="list-style-type: none"> <li>1) Accessibility, inadequate public transport facilities , flexibility in service provisions, different public perceptions of what is a disability. For instance an elderly person with motorised scooter is barred from using public transport and is forced to use a wheelchair which constrains their opportunities for work and social engagement</li> <li>2) DLA has been a life saver for millions of disabled people. It needs to meet the needs of today and also provide support for those over retirement age</li> <li>4) The mobility component should remain</li> <li>5) I hate mean testing because it creates unfair border lines often judged by individuals who assess by the number of ticks placed in the right boxes. Mobility should remain the main criteria and that does not mean solely physical handicap</li> <li>6) Greater support for independent living, access improvements to the living environment and more extra care facilities</li> <li>7) Working and consulting with User Organisations and by having independent citizens with knowledge of disability involved in the assessment process</li> <li>8) CERTAINLY THEY SHOULD. Personal Hygiene, mobility equipment &amp; Independent living support for eating, improved accessibility, dressing and sleeping is vital to improving quality of life</li> <li>9) Seek the guidance of User Organisation, cut out jargon, plain English and easy read versions and provision of advocacy support where needed</li> <li>11) Health professionals can have or may develop an overbearing manner or even infer they know best. Advocacy support should be more readily available to help vulnerable people and they should be helped to decide the most appropriate venue for a face to face.</li> <li>12) If DLA has been given for life then it should remain in place without creating fear as people get older or health gets worse. Certainly there should be a review in respect of shorter periods of awards, re assessment could reflect improvements and also deteriorations in health</li> <li>13) Recognise the roles of user organisations to provide advocacy support taking away fear of losing a genuine need of financial support.</li> </ol> <p>?) Greater access to CAB's and User Organisations. Fear of getting tied up in a bureaucratic inflexible scenario needs to be eliminated.</p> <p>?) Yes, improved local CIL's and support for local advocacy services is highly desirable</p> <p>?) I would prefer flexibility in the decision process, I have a fear that some providers would persuade some vulnerable people to purchase adaptations that don't meet their needs. I would prefer greater support for Independent Living Centres to prove help with assessment of needs.</p> <p>?) I am not sufficient knowledgeable or qualified to comment.</p>

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	<p>?) It's vital, the 3rd sector working in partnership with Care &amp; Health professionals should be more pro-active in resolving and removing barriers.</p> <p>?) My answer to question 19 could be an appropriate way. would like to see greater support being given to User Organisations</p> <p>?) There seems to be a conflict in the present structure with the equality act. I cannot see how DLA age constraints can meet the criteria of equality for all ages. I also have some concerns that we are not reaching and providing the right level of support to hard to reach groups</p> <p>?) My key concern is the lack of easy and independent arbitration of the decision processes.</p> <p>Disabled, older &amp; vulnerable people are more likely to live in fear of Big Brother perceptions than most citizens. I would seek assurances that the safeguards put in place protect citizens from any form of unfair discrimination and is seen to be effective and fair</p>
ONLINE570	<p>1) Availability of support from able people for those with learning disabilities which can be very expensive. Transport, many with learning disabilities cannot be safe alone on public transport or taxis and need someone with them. They then have incurred the cost of their own transportation plus that of a Carer. Daily Living, many with learning disabilities cannot shop for groceries, clothes or other essentials and need a Carer. Carer do not get paid enough to be there all the time, many are family members or friends. The government, even now with DLA, seems to impose care on friends and relatives rather than allow for someone to be employed by the disabled person. Disabilities are taken in isolation. Assessments are often done by GP with no specific holistic training in those with learning disabilities. They see a person able to walk and presume this covers mobility needs, they see someone who can dress themselves and presume their self care needs are covered.</p> <p>Example:</p> <p>My Daughter, 19 years old. Mental age similar to 4 year old.</p> <p>Can walk and run - Would get lost beyond the end of the road if alone, would get incredibly scared on public transport, is not safe crossing roads. Under current rules &amp; new proposals could be denied a mobility component. Has always had to get on appeal. She needs access to a car which a Carer must drive. If the government doesn't allow the funds for a Carer and relies on friends and relatives as they currently do, many with learning disabilities shall be trapped at home.</p> <p>Can Dress Herself - But cannot choose clothes, cannot decide when clothes are dirty, cannot take care of clothes, has very questionable personal care skills, uses a toilet roll a day, during menstrual cycle (period) uses 20+ pads a day. Refuses to wash her hair, indeed, cannot do so properly, will not have it cut.</p> <p>Can Leave the House - but has not ever had any friends. She does not have the social skills needed to maintain a friendship so all her social interaction has to be provided for her by a Carer. Social Services currently fund this at £18,000 pa but, I understand, this direct payments scheme is to be phased out. My daughters DLA does not start to cover this.</p> <p>Mobility component - A Conservative government already stopped this for those in residential placements if they were funded by the NHS/PCT. This was very shortsighted. My son (23) lives in a residential placement. He is health funded as he needs insulin injections, he has learning disabilities (severe) and it is vital for him to access the community yet, the government decided that all health funded placements were 'hospitals or similar' and so clients didn't need to access the community. You now plan to do the same for everyone in residential placements effectively trapping them or forcing the cost onto the Social or Health budget which pays for their care thus saving the country nothing.</p> <p>Work - Someone with learning disabilities may be physical able to work, with huge support could be mentally able but, this is no good if there are no jobs. They never have the opportunity to better themselves are then forced to be the lowest of the low living off minimal employment benefits. Disabled people too should have the right to a quality of life equal to the average in this country not the minimum.</p>

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	<p>Discrimination - despite legislation discrimination will always exist. This along with job availability must be taken into consideration when doing assessments and writing legislation.</p> <p>Night-Time Care - in the current assessment process there is little provision for the need of a Carer. My daughter may not need to be taken to the toilet, have tubes changed or require turning but she does require company. She can often be up until the small hours needing interaction and this is never considered when asking questions on application forms. Someone still needs to be there to do this, it is just as much a requirement but not seen as a cost. If Carers eventually are unable to cope with the lack of sleep the client goes into residential care where the costs are much greater than the preventative cost of DLA or its replacement.</p> <p>Cost Prevention - All too often disability funding is a crisis management approach. Wait for something to go wrong and then fund it. It relies heavily on the good will or Carers, unpaid friends and relatives of the disabled. With proposed legislation, these Carers may actually be forced to work leaving no one to do their caring roles. For an example ... I asked for funding for my son. He was in receipt of DLA higher rate for care and mobility but we needed funding to allow a Carer to come into the home for a few hours each day at a cost of £20,000 per annum. By the time this was agreed it was too late. My ability to care diminished after years of stress, the outside Carers were unreliable, the funds were not there for a better service and so my son went into residential care at a cost to the state of £115,000 per annum, £95,000 more than we eventually received each year. Had the needs been met, that cost would not have had to be incurred.</p> <p>What ever you eventually agree has to take account of the real costs of Caring for disabled people as a holistic proposal. In isolation those assessing claims could decide no entitlement which will only leave local authorities to fund care and for family and friends to provide services. When this collapses the country pays more. I appreciate £18b is a lot, too much possibly but, more needs to be done to think ahead. Many claimants now have to claim as though everyday was their 'worst' day. It may seem like fraud but it has become essential as on their worst days they are as disabled as they claim and this will prevent them from working, it will mean they will need extra care and increased support with mobility. If the benefit is not awarded they will go days or weeks with inadequate care unable to take care of themselves. Please focus future claim forms and assessments so that claimants do not feel the need to lie. Focus perhaps on asking how many days a month on average are the 'worst days' and calculate on a fair appraisal of what a fair amount of days of inability are for the average person. If they are said to have too many days of inability then they should be awarded an amount as though their worse days were every day. I hope this makes sense to you, it has to do for just about every claimant and, if it does not, proves how out of touch with reality you possibly are.</p> <p>2) Would it not be fair to link the upper age limit to the age of retirement? It seems wrong to me to say that a person over 65 can be of working age yet not entitled to a benefit supposed to aid their independence which could be their ability to work. I would also argue, and I know this costs, but, why should someone over the age of retirement not be entitled to a full and active life? The age of 65 is somewhat outdated as an age when people should expect a degree of disability, I would contest this may well be closer to the age of 80 or more now. Could a study not be done of at what age a person statistically could expect to have a disability qualifying issue? If, for argument sake, only say 5% of the population over 65 would be entitled as new claimants, is this not affordable? At what percentage of age would it be excessive? Base the cut off age at that and adjust as the average age increases.</p> <p>3) What guarantee will there be that decisions are not based on upon cutting costs? All too often with DLA claimants have suspected decisions were based on cutting costs with assessors instructed to deny benefit if any doubt exists at all or on a hunch with many claimants then being awarded the correct amount on appeal.</p> <p>Tick sheets awarding points per question are a good method but do not allow an element of common sense where, perhaps, an assessor finds the questions simply do not cover some of the issues the claimant may have, where one issue in isolation scores low yet, combined with another, scores higher. for example:</p>

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	<p>Can you get on a bus? - answer 'YES' score low or zero</p> <p>Alternate question which may not be available to the assessor: Can you get on a bus without needing someone with you? - answer 'No' score is high</p> <p>Questions must not be allowed to be weighted as yes or no. The need for a Carer must always be included and not presumed to be availability of friends or relatives which should be irrelevant.</p> <p>4) OK, in an earlier question we agreed the current system of two main categories was not working, that people cannot easily be assessed by using just 'mobility' or 'care'. The current system being two rates of mobility and three of care.</p> <p>The new proposal is two components with two categories each. In other words, the same as now minus one?</p> <p>I am uncertain how reducing by one will significantly improve understanding in any way or make administration easier. It would be clearer if you outlined the headings of these two sub categories as this is a significant bit of information.</p> <p>It is rather unclear now with DLA. Mobility component, lower rate for those who have some difficulties getting around but can probably manage alone and, higher rate which is for those virtually unable to get around without support from A N Other. I understand this is a gross simplification.</p> <p>If the new system is that simple then yes, I am all in favour of it. This will mean many with learning disabilities will automatically be entitled to the higher rate because they always need someone with them. May I ask that, if they do not claim to have any physical issues that this does not work against them in any scoring system.</p> <p>Those with physical issues should, as now, have a distance which is considered reasonable. What is reasonable for an able bodied person to be able to walk before they experience discomfort? If it is, for example, two miles then it seems reasonable that someone unable to walk a mile at the same pace as an able bodied person should be entitled to a lower rate. Many do not conveniently live 50 meters from all the services they have to access, we need to be realistic. Many have to access hospital which will often be several miles away. The 'local' doctor may well be a mile or so away, the nearest shop a quarter mile. Perhaps distance from services should be considered when deciding what is the distance a claimant should be able to walk without severe discomfort which prevents them from reaching a destination in what any reasonable person would consider to be an appropriate amount of time. I knew a chap, was turned down initially because he could walk 50 yards or meters which ever it is. What was not mentioned in his claim was that the amount of time it took him to do that was around half an hour and nowhere he had to go was anything like that close. Sadly, we do not live in an age where everything a person my need is no further than the walk to their street door. Home helps are unaffordable to many, meals on wheels has been stopped, community library mobiles are few and far between, milk deliveries don't exist in most areas now. Someone one said, "There is no such thing as society" which is all well and good but it does mean we now have to travel further for goods and services at an ever increasing cost.</p> <p>5) I have experience of some with autism who seem to have an automatic entitlement. It is true that they could do with the help of a Carer to manage budgets if nothing else but, the reality is, they are little less capable than someone who has no conditions at all. I employ a man with autism who receives DLA. He spends the money on gadgets and down the pub. He is, I have to confess, not as proficient in the role as a fully able person but the DLA doesn't seem to be a requirement of his care needs and would be better placed somewhere else. Sometimes certain conditions do qualify for automatic entitlement even though they are broad spectrum. One sufferer may be virtually incapable of most daily activities whilst another would present as 'near normal'</p> <p>There should be provision for some conditions which shall always mean a minimum level of life disruption and disability such as, perhaps, dialysis. I cannot imagine that this is any better for one sufferer over another. A cancer sufferer who may not be terminal but is on powerful treatments such as radio therapy may be another qualifier.</p> <p>6) This depends on each client. Some may consider riding a horse vital to their therapy, others it could be access to a regular massage, ability to relax at the theatre or, to others, doing the weekly shop or paying bills.</p> <p>Bare essentials which should be considered as automatic rights are the ability have regular shopping done for all their needs either on their own or with support. Ability to provide adequate heating and hot water and pay essential utility bills which may well include a mobile telephone. They may need extra support from a Carer to some or all of these things</p>

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	<p>*Access to the community - Taking the mobility component away from those in residential care is just plain stupid, excuse my use of language! To presume that someone being in a residential placement is anything like being in a hospital or similar is just plain wrong and does not take consideration of an individuals needs. It would be far better to consider a different approach entirely which would still save a considerable amount of money and see money focused where it is needed. I see your proposal on this as the main thorn in the side of the entire policy.</p> <p>Ask the question of each person qualifying of, Do they need to access the community as though they were living in their own home? A great many do. Quite often they are in residential placements because there is either no one available to care for them in their own home or because their Carers were no longer able to cope. Many simply have no one to manage the current option of direct payments. Their need to access the community has not diminished, they are still capable of going swimming, enjoying theatre or meeting with friends, they simply cannot manage all their own needs. To deny them a benefit which would still prove useful and beneficial to them is not in keeping with the spirit of your proposal and will be seen as directly what is, money saving for the sake of it despite overwhelming evidence that it will actually seriously affect the quality of life of many claimants.</p> <p>7) Well, time constraints are a solution but, presently the assessment seems to be based on an 'on average' basis which is grossly inaccurate and unfair. It ignores the level of disability on a claimants worst days leaving many claimants having to lie as though each day were their worst day. They may only have a weeks worth of worst days a month but, for those days there will be build up and climb down days and then, the rest of the time when they 'muddle along'. When taken as an average they may not seem too badly off or incapable but, imagine if the average person had flu for once a month lasting two weeks. On average they would have nothing more than a manageable cold all the time, hardly a qualifying disablement. But, the reality is, for the best part of two weeks they would have been incapable of leaving their beds requiring a considerable amount of care. This is how it is for many disabled. They have much of their lives where they are reasonably able and yet, much where they are totally disabled. It has to be that the disability outweighs the ability else we are to presume that their disability does not prevent them having the same quality of life the rest of us expect and understand to be reasonable.</p> <p>8) If the aids they use are easily available and that maintenance arrangements are affordable then they may be considered but, where does that stop? Someone with great difficulty getting around may own an old banger of a car, could this be seen as an aid they have which negates their need to a mobility component? A walking stick is not an acceptable alternative to free movement and should not be considered. Many can only afford a mobility scooter or electric wheelchair with their DLA entitlement, taking an existing chair into consideration is to presume they can always afford a replacement which, clearly, many may not be able to do. As technology for replacement body parts improves it seems logical that they will prevent a disability and should be considered. Hand rails in the bath, a bath seat ... these are helps not replacements for an often required Carer so, it cannot be presumed that they are going to negate appropriate benefit. In short, the questions should always be: Do you have adaptations? Do any of these negate your need for assistance?</p> <p>9) Get rid of those damn 'on average' questions! There is no such thing as an average day. Make it as widely available as possible to anyone likely to be able to assist in its completion. Try to consider others such as Carers ... if many of the qualifiers require the need of an assistant or Carer then they will be far easier to understand.</p> <p>10) DO NOT make this a requirement. Many actually have no contact with their GP at all. Many do not see anyone from a hospital. Those who are beyond school age may well have little or no contact with any outside agency and only the experience of their family applies. For many, once they have received a diagnosis or, indeed, been labelled, no further medical input is sought or required. A face-to-face for an hour may just not even get close to exploring the complex needs of those with learning disabilities. My daughter has had a psychologist for months and she still says she is no further on in her study of my daughter. More emphasise and trust has to</p>

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	<p>be placed in the evidence of current Carers and not to presume they are part of some conspiratorial fraud</p> <p>11) With learning disabilities the claimants own home may be best but, even then, inappropriate.</p> <p>12) Look, the very last thing Carers and those with learning disabilities need is constant checking up on their honesty. These reviews have historically always been to the same objective, pressurise the claimant into 'slipping up' and giving the impression their needs are not so great and can therefore save money. It should be enough in many ongoing conditions such as learning disabilities and certain physical conditions such as arthritis to merely ask, each few years, have there been any significant changes since the last check and to send the answers to the questions last time for there to be an accurate answer.</p> <p>13) Promise that unless a claimant has indicated their condition has improved that you will not look again at their entitlement with a view to reducing it. many are scared by the fact that each change of circumstances is treated as though it were a new claim especially those great many who only had their entitlement agreed on the basis of appeal. I know too many whose condition has worsened but they are too scared to notify the DWP in case they actually cut their benefit</p> <p>18) One of the key issues I currently think of is uncertainty. There has been an inconsistency of entitlement. Some may be awarded DLA for a year or two whilst others are awarded it for life. None of them actually mean anything and are little more than guidelines. So, if, for example, a person is awarded the mobility component for life, they should rightly expect that they should not have to submit for reassessment. Such things as a continued motability vehicle for them should be assured. This is not the case though. Indeed, a life time awarded claimant could be called in for reassessment well within the lifetime of the motability contract. If they lose the entitlement, their benefit stops immediately. This means they are in all probability going to lose their vehicle too even if the benefit is later returned on appeal. Claimants need to know, just like anyone else, whether long term financial commitments are a safe option for them. Everyone has the right to be able to budget and this is no less the case for the disabled. What the disabled also need is an identifier. Currently there is no way to identify a disabled person if they appear to be much like everyone else. We often get asked, "Are you registered disabled?" Did that ever mean anything? If it did, with who and how can one prove it? An identity card clearly signalling entitlement to whichever component would be very useful. For example, a theme park may offer a discretionary benefit discount to a disabled person and their carer, quite often they ask for the blue badge to be presented as evidence, all well and good except that the car is in the disabled bay of the car park! This will mean either the disabled person or their carer has to run back to the car park to return the badge, hardly ideal. With an identity card which is state sanctioned and contains a picture smaller but similar to a blue badge, such access would be easy to obtain to a wide range of services. Many potential providers of concessions will not provide them for fear of fraud, this would resolve that.</p> <p>19) With Motability, for example, there may be another way to ID entitlement but, as the money would normally come from the replacement to DLA, I cannot see this being a workable option. How would one prove entitlement to a blue badge? A disabled person and their Carer is really not going to want to have to submit a claim for each and every service they may access which will almost certainly involve complex forms and possibly interviews. This too has cost implications for local authorities so there would be no saving.</p> <p>20) With social care it is a dangerous approach to combine things. For example, right now they will consider such things as a motability car and make allowances for the client having one and expect it to be used for transportation, a very reasonable expectation. But, what of care? Very often the care component of DLA is for very specific and personal needs of the claimant. What social care usually provides is for additional care. Someone with learning difficulties may well require assistance in the home from their family or friends, quite often the DLA subsidises the family income to allow someone to stay at home and care for them. This should not be the case but it highlights the very poor provision there has been for carers for decades which continues to be the case. If social care decide to consider that element of income in their assessments then it will all go on providing the provision of care which used to be provided by day care centres and the like which have all but become extinct since the introduction of direct payments. The two must always remain apart from one another as social care simply cannot be trusted to make a fair judgement based on a</p>

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	<p>person centred assessment. My experience has always been that local authorities consider budget first, need second and only those who understand the law and how the system is meant to work get a full provision, everyone else gets a cut down service which doesn't fully meet their needs.</p>
<p>ONLINE571</p>	<p>1) Ignorance of disability unseen, ie my son is autistic, looks healthy as a horse but has many barriers to leading an independent life. Without quality support and from people who truly are qualified in working with autistic individuals, this support can be truly inadequate and indeed put these vulnerable people and the wider community in danger.</p> <p>2) I have no objections to a review of DLA. It is vital however that families caring for a disabled individual with autism are able to receive financial support in order to ensure their loved ones are adequately provided for. I am unclear really what this questions is trying to ascertain? None of us wish to have benefits cut to the detriment of our loved ones so essentially it would be easy to say leave the DLA as it stands!</p> <p>3) This is a difficult question to answer and very much depends on the type of disability ie, physical, mental or indeed both. Support is the main area that disabled people require and if necessary families or individuals should be able to access HIGH QUALITY support and be able to pay for it through their allowance.</p> <p>4) I personally would not have a problem with their being only one component to a claim for the new personal allowance, surely if the government is going to ensure that the professionals assessing these individuals are indeed experts in the area of the disability splitting into the two components should not be necessary. I have my doubts that at present, and based on personal experience, most of the people assessing claimants have the first idea of what the real problems are for families.</p> <p>5) ABSOLUTELY. Autism is life long, there is no cure. These individuals should automatically receive the highest rate of the new allowance.</p> <p>6) This is indeed the governments greatest challenge in my view. The activities which one individual deems essential certainly will differ greatly from another and from a family point of view. How does one define a full and active life with the disabilities which are encompassed within this huge melting pot!</p> <p>7) Ensure adequate review.</p> <p>8) Difficult to answer - aids are only this, they are not a solution always to a persons life long disability. Yes people should always have access and be able to obtain high quality aids if this enables the quality of their life to improve.</p> <p>9) The current form is absolutely inadequate, it is very difficult for most people to understand and in my experience the way the questions are displayed frustrating. In particular where the form asks how long a person can carry out a particular activity. Most people completely fall at this hurdle and in most cases the most needy are denied the benefits they are entitled to.</p> <p>10) School, family members, any health professional experienced in the disability. Currently as commented by others, people are discharged from health care and left to fend for themselves until a major problems occurs and then they have to get back into the system. Autism is a clear cut diagnosis and those assessing these claimants need to be qualified to adequately assess these individuals</p> <p>11) I am concerned by this greatly, a health care professional? This can be a health visitor, a nurse? I would expect only a qualified doctor in autistic spectrum disorders and its associated triad of impairments to assess my son.</p> <p>12) This would depend on the persons age, where they are in the education, welfare system, countless reviews would be extremely upsetting for families and individuals with ASD. Evidence/criteria would be dependent on the persons condition. Different types of review, not clear how this would work and how it would be useful.</p> <p>13) A simple questionnaire that can be filled in on line would be the ideal solution. Annual review would probably be the way forward here, depending on the disability. Clearly ASD if life long, a stroke, or other medical condition is subject to change and may need more reviews.</p> <p>14) Where to get help with completing a claim, how the claims are assessed, where to appeal.</p> <p>17) Children are constantly developing and families are already under great strain and have high levels of anxiety. The system for assessing and reviewing these claimants needs to be sensitive and again the qualified health practitioner only should be involved.</p> <p>18) Currently the DLA enables individuals and families to receive a cash benefit and enables them to choose how they wish to use this money to help their loved one or</p>

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	<p>themselves. If the new allowance attempts to give advice on how to spend this allowance I think this would be wrong.</p> <p>19) DEVASTATING. People and families must be able to have complete access to all support, aids required and this is what the current DLA payment gives.</p> <p>22) It is imperative that the autistic individual and the very high level of care given to them by their families is fully considered. ASD individuals are indeed able to live full and varied life with adequate support. The government needs to ensure that this new allowance gives them a passport to work that is fulfilling and above ensure they are adequately protected in the work place and that companies and public sector concerns give viable employment to those that can work. I have no problem with a reform or review of DLA as long as ASD individuals and their families caring for them receive a worthwhile and useful aid to their independence and they have a place in our society.</p>
ONLINE572	<p>1) A major barrier is inadequate disabled access in public places, including on public transport.</p> <p>2) It should remain non means-tested</p> <p>3) Disability equipment including mobility aids.</p> <p>Transport costs such as wheelchair accessible taxis</p> <p>Cost of fuel as poor mobility makes it difficult to keep warm.</p> <p>Higher insurance premiums eg surcharge on travel insurance.</p> <p>4) Having two rates per component could be easier to understand and administer, provided those currently on the highest rate do not lose out.</p> <p>5) The most serious impairments, particularly progressive neurological conditions, should mean automatic entitlement to the benefit.</p> <p>6) It is essential for people to be able to live in an environment where they are enabled to do as much for themselves as possible, and in areas of life where this is not possible, to have someone to provide appropriate care. As well as obvious things like food and drink and hygiene, it is essential for people to have opportunities to get out to meet other people in appropriate settings on a regular basis and to take part in creative activities and follow their interests as much as possible.</p>
ONLINE573	<p>1) Lack of wheelchair-friendly public transport. Lack of money. Dependency on others.</p> <p>2) DLA works fine. Where will the people come from to carry out the PIP assessments?</p> <p>3) Transport and heating</p> <p>4) There are already two components to DLA - Care and Mobility.</p> <p>5) Benefits should be based on need.</p> <p>7) The assessment should be reviewed periodically.</p> <p>8) Wheelchairs; adaptations to the disabled person's home. These are all expensive and should be included in the assessment.</p> <p>9) 1. Shorten application forms. 2. Ensure that the form is written in simple and plain language.</p> <p>10) Evidence provided by the individual if they are able; or their carer, family, or care staff if in residential accommodation.</p> <p>11) Many disabled people have little or no contact with health-care professionals, therefore a face-to-face meeting would be inappropriate as they will not be aware of the full extent of a person's disability</p> <p>12) 1. The extent of disability and the impact this has on a person's life should determine the frequency of reviews. 2. Yes.</p> <p>13) If the PIP is reviewed regularly, people will keep the department informed. ?) They use their DLA, particularly the Mobility Component for wheelchairs, other aids and transport.</p> <p>17) The rapidly changing need of children as they grow up; hence a need for more frequent reviews than for adults. ?) Vital. ?) DLA should not be ended until EVERY PIP is in place ?) All these proposals should also apply to those in Residential Care, particularly the mobility component</p>

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ONLINE574	<p>1) There are no changes to cover mentally ill people, DLA forms are not geared towards those with mental illness, and the new proposals seem to be the same.</p> <p>2) Regarding mobility, again this is geared towards those who are physically disabled and cannot get around. Those who are mentally ill have as much difficulty with mobility if not more in some cases, yet the present DLA criteria does not include questions about how a mentally ill person copes with everyday tasks due to memory impairment or confusion.</p> <p>3) Again, this is geared towards physically disabled people and does not cover those with mental illnesses. Someone who is disabled may be able to get around, cook their own meals and go shopping, whereas a mentally ill person can't in some cases depending on their illness. The questions on the new PIP forms must cover every disability, to ask if someone can sit for 2hrs or 6 hrs is fine for someone in a wheelchair or someone who has difficulty walking, but for someone mentally ill, they are unable to sit for any length of time in some cases, and in other cases may sit for hours staring at the wall. So if the latter was the case, would that mean that person could be seen fit to work and not eligible for PIP?</p> <p>4) I think there is a need for two rates. Some people who are disabled may be able to get around, while others may not. Every person has different needs. The only problem I can see in having two rates, is again whether the person is physically or mentally ill. A mentally ill person sometimes has as much difficulty getting around as a physically ill person. So the criteria for the equivalent of the mobility rate should take into consideration whether the person is capable of getting around not whether the person has difficulty walking. Mentally ill people can walk perfectly, their bodies are healthy, but if their minds are confused they can't get around as they don't know where they are or where they're going. Depending again on what mental illness they have.</p> <p>5) I believe some terminal illnesses should be eligible for automatic entitlement. But all other claims should be based on the needs and circumstances of the individual applying.</p> <p>6) Being capable of preparing and cooking your own food. Personal hygiene (washing and bathing) and being able to dress one self. Medicating one self correctly. Being capable of going out and getting groceries. Remembering GP and Hospital appointments Being capable of managing finances and paying bills. Communication with others. Living safely at home without being a risk to one's self or others. Eating regularly and properly. Mobility in the home, managing stairs and steps, and generally getting around safely indoors. Mobility outdoors, walking etc. Physical and mental capability to live as normal as possible</p> <p>7) Difficult one. Maybe a quarterly or six monthly update form to both person claiming PIP and their GP. With variable and fluctuating conditions their very nature would make it difficult to assess and I think a blanket assessment would be appropriate to cover all eventualities.</p> <p>8) Yes aids and adaptations should be included. Assessment should take into account both those where the person already has them, and those that the person might be eligible for and can obtain.</p> <p>9) It would be easier to fill the claim form in if it wasn't multiple questions for all disabilities. Some of the questions on the present form do not apply to some disabilities and some disabilities are not covered at all by any questions. Anyone receiving Incapacity Benefit or Long Term Incapacity Benefit should be sent the forms for PIP automatically instead of having to apply for them. A leaflet about PIP should be given to everyone at the onset of them receiving Long Term Incapacity Benefit so they know they will be receiving PIP application forms and explaining exactly what PIP is.</p> <p>10) The person's GP knows the person's medical history and condition, and is best placed to provide such information to help provide a clear assessment.</p> <p>11) The healthcare professional should be medically trained to deal with physical disability assessments, and a psychotherapist or mental health professional should be available for mentally ill people. The only difficulty I can foresee is if the 'healthcare professional' is not trained or has no knowledge of the person's disability when assessed, ie; a medically trained healthcare professional assessing a mentally ill person.</p>

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	<p>I can't see any difficulties for physically disabled people to see a healthcare professional, other than mobility problems, but for mental disabled people any confrontation can be damaging or extremely stressful causing more harm than good if the 'healthcare professional' is not a psychotherapist or mental health professional.</p> <p>12) A simple questionnaire to the persons GP again this could be incorporated in the quarterly, six monthly or annual 'update' from the person's GP. Yes there should be different types of review, as all disabled persons needs are individual to that person.</p> <p>13) Again, physically disabled people can report changes in their needs or circumstances, mentally ill people may not be capable of doing so, and would be penalised for not reporting any changes simply because they are not capable of doing so. Changes in circumstances would be covered in the 'update' report from the individuals GP.</p> <p>14) People applying for PIP would need to know what help is available for their particular disability. Whether it be counselling, medical aids, etc.</p> <p>15) Perhaps this could be covered in a leaflet given to everyone claiming long term incapacity benefit or those already on DLA explaining what PIP is. One leaflet given at the onset of a claim or sent to those already in receipt of DLA could explain everything about PIP and also explain they would receive the application form for PIP at the end of twelve months of Incapacity Benefit.</p> <p>16) Those that have to fund aids privately could be eligible for a one off payment via PIP to cover the cost of the aid(s), but be seperate to their PIP payments. Something like the Social Fund payments to those unable to afford a cooker or household item, but purely for medical aid(s). I don't think using PIP to meet a one off cost for an aid would work, as they probably have to budget and a lump sum from their PIP allowance may cause problems with their budget and they may have to go without something else. Unless they weren't eligible for PIP in the first place but were eligible for help with an aid, in which case they would use PIP as a one off payment.</p> <p>17) One key difference is care of the child, the parents may be eligible for Carers Allowance, but usually one parent is unable to work, due to caring for the sick child, therefore something should be in place to assist that parent, perhaps a relief carer for respite. Educational needs could be included.</p> <p>18) I think DLA has been very important in getting disabled people access to other services or entitlements. I do feel that people receiving DLA should be entitled to help with things like rent and council tax, but perhaps this will be covered under the Universal Credit scheme.</p> <p>19) I think this would cause a lot of problems for people financially, as some in receipt of low rate DLA and low rate Mobility struggle at the moment.</p> <p>20) If the present system is to be streamlined and easier for both the claimant and the government departments, surely the PIP assessment and forms could cover local authority care assessments and other support assessments, and ESA would just cover what is now JSA and Income Support?</p> <p>21) The policy needs to define disabilities better, and distinguish between physical and mental disabilities.</p>
ONLINE575	<p>1) Lack of local bus services outside of Mondays to Fridays peak hours.</p> <p>Current high cost of fuel for my Mobility car, even though I am in work.</p> <p>General lack of understanding by some health professionals and most of the public of how dilated cardiomyopathy affects those who have this condition e.g. I can't walk very far without becoming breathless; I can no longer do my own houswork or gardening - yet nobody can tell this by looking at me.</p> <p>2) Keeping the link to Motability car eligibility, and to other benefits such as eligibility for Disabled Rail Card.</p> <p>3) Transport costs - price of fuel, cost of bus and trainfares. Additional costs for help with simple tasks such as housework or gardening. Additional costs if adaptations are made to the home but no local authority support available. Additional heating and lighting costs if working from home more than other healthier people.</p> <p>4) Depends on how high each individual rate is set - if this is just a cost-cutting measure,</p>

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	<p>some people may lose a lot of money.            What happens to those linked benefits that are dependent on someone receiving a certain level of DLA ? Will they be withdrawn as well ?</p> <p>5) Some automatic entitlements should remain - and the list should be expanded to include long term conditions (why isn't cardiomyopathy on the list ?)            The list of conditions or impairments eligible for automatic entitlement looks as though it was drawn up in the Victorian era - it is not fit for purpose.</p> <p>6) Ability to wash / shower / bathe, ability to cook, ability to do own cleaning of house, gardening, anything that requires physical exertion but can't be done - it is demeaning not to be able to do these things and not receive any support / help.</p> <p>7) Ask health professionals such as GP's, consultants for opinions on a regular basis. They will see their patients more often and understand their conditions / impairments much much better than health professionals employed by the DWP, whose sole purpose will be to reduce the number of successful claimants.            Recognise that some conditions / impairments really are for life - so there is no point in causing unnecessary distress / anxiety to those people if the end result of every review of the benefit is still 'no change'.</p> <p>8) Yes - but only if they help a person with those tasks they can't normally do for themselves.</p> <p>9) Ensure appropriate charities know their members will be eligible for the new benefit. Ask charities to help in designing the new application form.</p> <p>10) Letters from GP's and consultants detailing their patients abilities.</p> <p>11) Healthcare professional needs to have already received information from claimant's GP / consultant before attending for the interview - then an indication could be given at the interview whether a claim is likely to be successful - rather than waiting for 3 months for a decision as currently with DLA application.</p> <p>12) GP / consultant view if this is a long term condition that won't improve in the future - then review every 5 years.</p> <p>13) Condition has to have changed for at least 3 months before notifying DWP - so payments aren't cut for a short term improvement in a condition.</p> <p>14) Availability of help from local authorities / PCT's / charities etc relevant to particular condition / impairment.</p> <p>15) Avoid over-bearing pressure on already vulnerable people.</p> <p>18) Once eligibility for PIP is established, automatically pass that information to the relevant agencies / organisations - so no need for claimant to send copies of entitlement awards to these outside agencies.</p> <p>19) People won't claim what they are entitled to.</p> <p>20) As much as possible, provided the claimant agreed for the information to be shared - especially so for medical records / information.</p> <p>22) No</p>
ONLINE576	<p>1) 1) transport to and from venues</p> <p>2) additional costs associated with disability</p> <p>3) accessibility to All elements of venue, not just some parts</p> <p>3a)An exhibition might have accessibility but 'special' element may not.</p> <p>4) I suspect that the complexity of creating up to 11 different rates in current DLA is more of a problem for Government than the users. Assessors will be aware of pressure to control costs and will tend to put people into the lower grade or say they don't qualify because two grades is too coarse for a proper assessment. (why don't you have just an A or B grade for 'A' level exams? see what I mean, would not reflect the ability of the candidates.</p> <p>7) It will be necessary to set up annual assessments or rely on individuals reporting changes.</p> <p>8) I can see that this is a difficult issue, but we need to move away from a system where there is a dis-incentive to improve one's condition. So, No, the assessment should not take into account the availability of adaptations and aids. Having the use of a powered wheelchair hardly qualifies as improved mobility if you take an active human being as a starting point.</p> <p>11) This is important, but it must be with a qualified professional. It can be very distressing to discuss your condition with a stranger knowing they are then going to make an assessment of your eligibility for some payments. Many disabled people have complex</p>

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	<p>conditions and needs, which even GPs rarely come across, so how can an assessor be expected to make a fair judgement. Maybe you will need to set up a system whereby you have two levels of assessor or, equivalent to the GP's specialist referral system. The main assessors have the ability to refer a disabled person to a designated specialist who is capable of giving a fair assessment knowing their condition?</p> <p>6) Your focus should be on what activities allow the person full independence, this should drive priorities; historically, I think, more emphasis has been placed on availability of carer support, but in all cases we should focus on what the person can do and how to make things more accessible for them both inside and outside their home</p> <p>9) Make it easier for your target people to know of its existence. Many people become disabled through accident and illness and have no idea, what to do next. They are pre-occupied with coping with their new status and regaining their health, so other government agencies must link into the new PIP system. In my example, I was told that I didn't qualify for DLA, because I must apply within 3 months of my disability. When I was in hospital for five months and knew nothing of the world of benefits or how to claim them</p> <p>10) This must be viewed from two angles. Government must state who they are prepared to support and then the individual must be able to demonstrate that they qualify, either themselves or through the assessment of a designated expert. As you planned new label PIP recognises, Disabled is not a very helpful label and lacks any useful definition. We all want to avoid tick box assessment but you have no alternative for a phase one assessment of 3 million people (with subsequent referral to an expert if this is deemed necessary)</p> <p>12) Yes, there should be different frequencies. Many chronic conditions are known to merely deteriorate and it would be really upsetting to have assessors visit regularly to demonstrate the difficulties you have to deal with everyday. I accept that Government does want to have a way of reducing the number of people registered for benefit as well as a way of adding to it. But forcing all people to submit to reassessment at the same frequency cannot be necessary.</p> <p>13) Like everything in life, there will need to be incentives and disincentives; I suggest that you have a simple confirmation of condition form that the recipient of PIP has to sign and return, maybe with a few critical specific questions that the recipient has to answer. (clearly, with a freepost reply envelope)</p> <p>14) You should be aware of experience, or otherwise of the applicant. If their disability was recently acquired, they may have little experience of coping and therefore may find answering questions quite difficult. Should you consider setting up 'Test Centres' where applicants could go to submit their responses, where help could be offered on their responses (Local Authority building/Health Centre?) Could you set up a specialist portal for queries on PIP where you could get an interactive response?</p> <p>15) This sounds oppressive, but could be less so, if you just had to state that you are aware of advice centres available to you at, say libraries, health centres etc</p> <p>16) We have assumed that it is our responsibility to fund any changes that I need. If the new PIP is expected to fund changes/equipment, then you would need to allow grants to pay for them and as a minimum allow payback over many months or even years. This group of people have a low standard of living already so it seems unreasonable for them to try to pay for necessary changes to improve their situation from this low level. Clearly your current recipients cannot all meet the criteria you create for PIP, so your efforts need to go into identifying your true constituency.</p> <p>17) That they are children and that they are entitled to live a life as much like other children as possible. How can they be given the chance to opportunities open to able children?</p> <p>18) DLA has been an essential lifeline for my people. I am not aware of any additional access to services that I get through DLA, unless you mean Motorability. Clearly an ID card 'like a bus-pass' giving discounts for services would help.</p> <p>20) I'm not clear why you need to replace DLA rather than modify it.</p> <p>Clearly you have a problem with the way it is applied or you would not have 3 million people on the DLA. So why don't you decide who you are prepared to support and then get an appropriate system to identify and approve those who qualify? People with disabilities should not be made to pay for bureaucrats who have let the system get out of control. My worry is that genuine disabled people will lose out as the systems change from DLA to PIP.</p> <p>Clearly your 45 page consultation document will not have been read by many disabled</p>

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	<p>people. I don't know whether there has been a consistent approach to the public consultations by different councils across the country, but Wokingham, my council, have made a good effort amongst known disabled groups. I think appointed focus-groups of disabled people might have produced a better and more useable response to your questions.</p>
<p>ONLINE577</p>	<p>1) Money, situations and attitudes. For example, having to pay for a wheelchair and adaptations.. many people's lives are limited just because they don't get enough help and can't afford to fund it themselves. They may get a care package but not enough to go out of their home. Their condition may mean they need full-time assistance, or it may be that they get very tired and need very flexible employment, if any, which simply doesn't exist. Disabled people's needs vary hugely, but with a progressive condition (such as MS), lives can be very limited - and changing attitudes would not be enough to help the person. Money and time is also needed. For wheelchair users, the barriers to participation are still huge - negotiating the public landscape is not easy. Everything has to be planned ahead.</p> <p>2) Life awards should still be possible. Some people have conditions which are not going to improve. It is very stressful for them to be reassessed.</p> <p>3) Personal care, special adaptations/accessories, transport costs (taxis etc). Washing is often an additional cost. Equipment in the home. Food may be more likely to be expensive because of inability to cook. Heating is likely to be an expense because of the need to keep warm when unable to move around.</p> <p>5) Some health conditions/impairments should mean automatic entitlement. I think this applies particularly to progressive conditions. If someone cannot use their limbs (or does not have them) then it seems clear they will always need personal care; there is only so much that special adaptations can do, and in any case these do not come free.</p> <p>6) People must be able to keep clean, fed and warm, to get out of bed, to meet with others. For quality of life some degree of social activity, if desired, and the ability to get out of the home.</p> <p>8) I don't think aids and adaptations should necessarily be included unless it is clear that the person does not have to pay for them. In practice many people have to pay for wheelchairs for example - it would be unfair therefore to take into account that these are available. None of these things are easy to obtain. Eligibility is complicated and would make the assessment costly if it had to be considered.</p> <p>9) Make it clear that it is not about actual conditions or how disabled someone is - it is about needs and mobility in order to have quality of life. The claim form 10) In many cases it is not healthcare professionals who really know how someone's disability affects their needs/mobility - it is the people who see them most regularly and provide their care. So GP or social worker may know more about things. Also I think the system needs to recognise how hard it is for some people to attend appointments - healthcare professionals would get a more accurate impression from seeing their home environment.</p> <p>11) The claim form could be much more directive and made relevant to the legislation so that people can give useful information.</p> <p>4) Having a third rate for the care component enabled some lower level needs to be addressed. For example, people who can wash and dress themselves but can't cook, wash up, clean their home etc.</p> <p>7) Talk to people who work with the claimant. The claim form should ask about people's worst days and how often these happen.</p> <p>14) Absolutely. Ideally everyone would have a specialist adviser to help them with the claim form. People need holistic advice from someone who understands all their entitlements including help with personal care from the council and help with the costs of aids/adaptations.</p> <p>15) Such a system could work if it acknowledged that some people don't need it. It should be bypassed if people feel confident that they already know what they need to know. The system must be flexible - not wholly online or by telephone - so that people can access it in the way which best suits them.</p> <p>16) No - aids and adaptations should be funded as they currently are. It is not fair to use this type of payment for one-off costs for things that someone only needs because of their disability. At the moment people get some means-tested help but often have to make up the money from their own savings, or go without. But the PIP should not be used for these things, but for extra care, transport or other costs which help improve their quality of life, not things which are essential.</p> <p>17) All children need care of some sort so it is extremely important to take developmental</p>

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	<p>needs into account. Also quality of life for a child includes quality of life for the principle carer.</p> <p>18) Vital. This should continue. Passporting could be improved by not requiring additional claims. People should not have to take their benefit letters around with them - some other form of proof of entitlement could be issued.</p> <p>19) Huge - there would have to be an assessment procedure for all the other help as well, which currently isn't necessary. So it would end up being more costly.</p> <p>20) Help with social care via the council could be shared - an assessment of care needs could contribute to what information is needed to get PIP.</p> <p>21) As you've shown above, people in some ethnic minorities are less likely to receive DLA. More effective publicity and routes to claiming are needed. Plus it should be possible for supporting evidence to be provided by a wider range of people, with suitable checks.</p> <p>12) You could quite simply stop payments if people do not respond every so often. This isn't about reassessment but encouraging people to answer a set of questions at regular intervals.</p> <p>14) Information about social care provision in their area and other benefits they can claim. Holistic advice should be provided. Local and national support for their particular condition.</p> <p>?) Yes, but it would need to be flexible - not just provided on internet/telephone.</p> <p>?) No, funding is usually not sufficient and people have to make it up with their own money, or go without. People should not have to use PIP.</p> <p>19) Very problematic. It's essential it continues to be a passport. Otherwise different assessments would be needed for other help.</p> <p>?) Developmental issues need to be considered, and the fact that the carer's quality of life is important as well as the child's.</p> <p>18) It shouldn't be necessary to use your decision letter all the time - a system of passporting involving a card or some other secure means of proving entitlement would be better.</p> <p>20) Social care assessment could be combined - this looks at needs and includes relevant information which then has to be repeated and confuses people.</p>
ONLINE578	<p>2) Many thousands of disabled people have been in receipt of DLA for many years and like myself have been awarded the benefit for life because their condition will not improve such as in my case having a degenerative condition that in effect cannot improve. Do you not think that these people should be allowed to retain the benefit for life as awarded rather than have to undergo the stress of having to qualify for the new benefit</p>
ONLINE579	<p>1) The fact that the DDA is not enforced for example newly renovated banks have poor access and counters which which a wheelchair user can not see over. Also newly built accommodation which can have no ground floor, forcing wheelchair users to use unreliable lifts. eg when there's a fire they are disabled, a powercut they don't work and when they are out of order which seems to happen on a semi frequent basis.</p> <p>3) - Transport</p> <ul style="list-style-type: none"> <li>- Hospital appointments due to missing work and having to make special arrangements.</li> <li>- Adaptations to home</li> <li>- Special diets</li> <li>- prescriptions eg glasses and medication</li> </ul> <p>5) It should be based on an individuals needs and circumstances.</p> <p>6) being able to get about. being able to look after yourself in your own accommodation.</p> <p>7) Regular reviewing of circumstances.</p> <p>8) Aids may help to make life easier for the individual with disabilities, but may cause other problems, eg for wheelchair users, such as there not being lowered kerbs, uneven surfaces, cambers, steep hills, thresholds and not being able to reach many things such as in shops.</p> <p>9) make the form accessible by allowing people to do it online, this would therefore allow individuals with a visual impairment to use specialist computer programmes to fill it in. It could also make it easier for people with poor manual dexterity to fill it in online. Make sure there is clear information in hospitals and that health professionals know where to send people to access the information.</p> <p>10) GP's do not necessarily know the individual that well and therefore can not necessarily comment effectively. These people may have a better understanding of the impact their disability can have, physiotherapists, Opticians and maybe someone who knows the individual well in there day to day life.</p>

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	<p>12) How changeable the disability is and the age of the recipient.</p> <p>13) Make sure it is easy for the claimant to notify changes and ideally not have to go through the entire claim process again.</p> <p>14) Advice on what individuals with disabilities can access.</p> <p>16) Many disabled people currently fund their aids and adaptations through fundraising, grants, help from relatives and charities. Yes it should be an option to Personal Independence payment to meet one off costs.</p> <p>18) useful for getting things such as the disabled persons rail card.</p> <p>19) Some services require DLA as evidence and there isn't really an alternative.</p>
ONLINE580	<p>1) A lot of organisations responsible for the care and support of disabled people and children are ignorant to their conditions and how it directly affects their lives. They generalise too much. My son has DLA higher rate care (he age 6) and has T1 diabetes with insulin pump and CGM sensor and needs constant care. This directly affects his ability to access integrated education for example, yet the LEA do not recognise his needs. The system for assessing children with T1 is postcode lottery the online diabetic community know of children receiving higher rate care in one part of the country and middle or lower rate in other parts. Children cannot be relied upon to give the information required as they cannot fully understand all the details/implications. The forms are also too lengthy.</p> <p>2) Children and adults should be kept as separate forms and assessments. Perhaps the childhood age should be altered to correspond with child benefits clause on age (ie if in full time education then age 18??)</p> <p>3) The unforeseen costs - such as with T1 diabetes in a child the cost of glucose tablets/hypo treatment is not included on prescriptions. Also the extra costs of starchy carbohydrates being provided to the school for snacks.</p> <p>4) DLA forms are long enough as they are. Would the new system create longer/more forms??</p> <p>There is a grey area with regards care/mobility and I am unsure if having 2 rates would reflect this.</p> <p>5) I think terminal conditions should be given an automatic rate and perhaps the system made easier and quicker as the person and their families would be suffering enough hardship already.</p> <p>6) Access to activities/people is vitally important. Those who cannot assess these would have significant difficulty with everyday life.</p> <p>7) Perhaps a yearly declaration such as the tax credit system?</p> <p>11) Children should not be required to do this. However, a child's consultant could supply a declaration on their behalf?</p> <p>?) Some conditions are directly affected by growth spurts/puberty which adults would not have.</p> <p>Children's ability to have support will directly affect their ability to adapt to adulthood. If a child struggles all through childhood they will become a dependant adult.</p> <p>?) I do not think the current system gives clear information on other services or entitlements. It appears that those that know the system always benefit those that don't go without. For example my son has DLA (he age 6) I get carers allowance for him and have recently had a baby. I did not know I was entitled to the sure start grant because of the DLA.</p>
ONLINE581	<p>1) Access ; restricting what you can do - such as when shopping/travelling all present a challenge.</p> <p>Communications ; sight and sound. This site is a good example of small print which is restricting.</p> <p>New innovations such as technology/equipment - can help but often are expensive and also not known about.</p> <p>Self esteem - everything takes longer, patience required in society.</p> <p>To lead full independent life, it will involve addressing the issues funding to allow this to happen - such as adapting a person's home which is outside the remit of this review.</p> <p>2) People over 65 receiving the DLA if in a residential/nursing home should continue to</p>

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	<p>receive the benefit without the need for further assessment to attend a review</p> <p>2) People in care/nursing homes aged 65 and receiving DLA should not have to attend a review, and continue to receive the allowance. Also exclude from completing form as this would be difficult for many residence to complete. Why not switch them to AA</p> <p>3) Taxi for transport such as for carrying wheelchairs, cars if purchased under mobility scheme.</p> <p>Specialist equipment, house adaptations, bought in services - are all extra which a disabled person buys to help with making life easier</p> <p>4) Two rates per components is a fairer system than just one rate. It will prevent a person being excluded from any help. Having 2 rates will cost more to the government.</p> <p>5) There should be some automatic entitlements such as those in nursing homes as it probable the NHS has already done an assessment of needs. It should also cover individuals with permanent and long term conditions.</p> <p>6) Look at providing independence/quality to the individual at home, including in a care home. Mobility, daily care needs and assistance with domestic/work/leisure for a full and active life.</p> <p>7) This will be admin burden/not cost effective if the system is too cumbersome to operate. The work involves outsourcing for the assessments and the costs should not exceed the savings made by introducing the new system. Information on a persons condition could be obtained from consultant - however if a condition is permanent then the variable conditions are likely to arise, and do need to be noted as part of the disability.</p> <p>8) Aids and adaptations should not be considered to the detriment of excluding a person from the allowance - just because they have these. It should be remember these have to be used, often it can be timeconsuming, involve extra costs and effort. Considering new aids etc is an area for social care to advise and could get the scheme going beyond its remit. They could refer on to a specialist service. The aids and adaptations should not work to the disadvantage of the claimant.</p> <p>10) Hospital, GP, Specialists, Social workers - having contact with the person.</p> <p>11) This should not be used for over 65's in nursing homes - as it could be very stressful for those who are unwell. This area needs a separate consideration. Face to face does mean the persons disability can be seen and questions asks relating to the individual disability. It may be necessary to access at a persons home in certain circumstances. However, this will be a costly review to assess all claimants under 65 and should not out weigh the benefits of the changes. It could become an admin problem with so many people to deal with and reviews in future years.</p> <p>12) There should be different types of review depending on needs, with specialists in different conditions such as sight, hearing, etc. Frequency - if too often could burden the system and make it unworkable and produce no benefit to the exisiting DLA system. If an individual attends hospital, prehaps a specialist could certificate their condition at the consultation - at prescribed intervals - to avoid going to reviews and this would save on cost.</p> <p>13) 1. provide a form on line 2. when benefit granted send a form which should also contain address to return to. This could be a tear off form prehaps highlighted in large print in say red ink.</p> <p>14) Could refer to appropriate area - such as social services, RNIB etc Also have a supply of literature available people could have/information sheets. At review centre - have an information point with literature etc - could be staffed by volunteers Make sure organisations can provide information at these review centres.</p> <p>15) see reply at question 14. Could encourage GP's to hold information days, coffee mornings, evenings - to encourage claimants.</p> <p>16) Yes - or specific grant for equipment. It is important to have the aids/adaptations as it makes everyday living easier and needs to be encouraged</p>