



Disability Living Allowance: revision and appeals

Updated November 2015

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Introduction

This guide is for people who have had their claim turned down for Disability Living Allowance (DLA) and wish to appeal the decision. It is also suitable if you have been awarded some DLA but you feel that you should be on a different rate or component. For example, you may have been awarded high rate mobility and you think you should also get the care component.

Please note: the information in this factsheet is correct at the time of publication. However, the Welfare Reform Act 2012 abolishes DLA and replaces it with a new benefit called the Personal Independence Payment. This will affect new claimants from 2013 onwards.

What to do if you disagree with a decision

A decision letter will tell you if you have been awarded DLA. You may have been awarded less DLA than you hoped for, so you may have got low rate care and nothing for mobility, or you may have not been awarded any benefit at all.

You can challenge both these decisions. There is nothing to lose financially if you have been turned down completely, but if you have been awarded some benefit there is a possibility that a different case manager or a tribunal may reduce your award or stop it completely. This is unusual but it can happen.

First of all you will need to ask for a Mandatory Reconsideration, this means that the DWP will look at your case again to see if the decision can be changed. If the decision is not changed in your favour, you then have the right to appeal to an independent tribunal.

Mandatory reconsideration

You can ask for a mandatory reconsideration either over the phone or in writing. We would suggest putting it in writing so there is a record of it.

You will probably not be able to go into much detail at this point as you may not have been sent the medical report yet and will not have seen all the papers relating to the decision.

You need to request the medical report and any other reports that were used when making the decision as soon as you can. If you intend to send in further evidence after you have submitted the reconsideration request make sure that you explain that you intend to do this. The DWP should give you time to submit your extra evidence if you tell them you are going to do this. You will need to ask for the date when you need to send it in by but you should be given a month within which to do this.

The DWP are not intending to introduce a time frame within in which they must process a mandatory reconsideration request.

Once your reconsideration request has been received, a different case manager will look at all the evidence again to see if they can change the decision. DWP guidance states that as part of the mandatory reconsideration process, the decision maker will make a telephone call to the person to clarify any matters that they are unsure about and to explain their reasons for the decision.

It is not clear if everyone will be contacted by phone, or just some people.

The guidance also says that if they are not able to contact you by phone they will go ahead with the mandatory reconsideration using the available evidence.

The DWP may advise you to send in further evidence and may suggest what evidence is needed. DWP guidance states that if the DWP agree – and you would need to check with

them first – that a certain piece of evidence is required the DWP may be able to pay any costs that arise from this.

If the decision maker does not change the decision, you will receive another letter (the mandatory reconsideration notice) and will then have one calendar month within which to appeal to Her Majesty's Courts and Tribunals Service.

It is really important to stick to the time limits for requesting a Mandatory reconsideration.

Making an appeal

An appeal must be lodged directly with Her Majesty's Courts and Tribunals Service (HMCTS). This is known as direct lodgement. You will need to enclose a copy of the mandatory reconsideration notice with the appeal. When the Tribunals service receives your appeal they will write to the DWP for their response. The DWP are meant to respond to this within 28 days.

The form to use when appealing is called the SSCS1 form and is available at <http://hmctsformfinder.justice.gov.uk/courtfinder/forms/sscs001-eng.pdf>

You can send in further evidence after you have submitted your appeal, but don't delay in sending the SSC1 form back-it is really important to stick to the time limits.

Preparing your case

It is essential that you are familiar with the criteria for DLA and can demonstrate how you meet it. So firstly look at the criteria (see Appendix I on p 14) and consider how it applies to you. You also need to think about obtaining supporting medical evidence for your case (see p 9).

When considering the criteria, remember that it is not just about the help that you actually get but the help that you require that counts. You will also need to think about all the problems that you have with activities that you undertake throughout the day, for example, getting in and out of bed, washing, dressing, moving about, managing medication, communicating and so on.

If you have difficulties with cooking a main meal this is one route to low rate care.

If your condition changes over time as is usually the case with M.E. try to think about how you are most of the time.

It is likely that you experience some symptoms and are restricted in what you can do all the time so if this is the case make this clear. You may well have adapted since you have become ill and got used to how you are and this may mean that you underestimate the difficulties that you have.

It can be helpful to talk this through with someone who knows you well and knew you before you became ill.

You need to think about examples and how you will present your evidence to the tribunal.

Getting help

If you can it would be helpful to find a representative who can help you prepare your case. This would usually be a Welfare rights worker. Unfortunately it can be difficult to find this help but on the section of further help we give some ideas of where you may be able to find support with your appeal.

If you are not able to find a representative it is still worth appealing but it will be harder work for you.

Going through the paperwork

It is important that you go through the DWP's submission and any medical reports in detail. If you have a representative they will also need to read and examine this paperwork. This is where you can really start to see why the decision has been made and if there are statements that you disagree with contained in the evidence. There may be factual errors that you need to correct as well as opinions or assumptions that you wish to challenge.

Gathering medical and other evidence

If you had a medical with ATOS as part of your assessment for DLA you will need to go through the report making note of any inaccuracies and assumptions that have been made that you wish to challenge.

It is important that you try to obtain supporting evidence yourself. Hopefully your own GP will be prepared to help with this by writing a letter or report. You may also have a consultant or specialist who can help. If you are seeing anyone else in connection with your M.E. such as, for example, a complementary therapist or a physiotherapist, you could also see if they would be willing to write a letter of support. Friends, carers or relatives can also provide written statements that may give useful information about how you are affected.

You can either write to or talk to the people that you would like to get evidence from. If you write to your GP or consultant the tribunal will probably want to see copies of the letters that were written by you to request information.

If you have a representative from an organisation supporting you, they may be able to write off for the reports on your behalf. This obviously takes the pressure off you and may be beneficial. You need to try to get your medical evidence sent in before the hearing. If you do have late evidence it is still worth submitting it or even taking it on the day but the tribunal may not accept it.

Medical and supporting evidence needs to be relevant and not too lengthy. Ask people to specifically refer to information relating to DLA. For example, if you are not able to walk very far then ask them to make a comment about this.

Upper Tribunal and commissioners decisions

You do not have to use commissioner's decisions or upper tribunal decisions as supporting evidence but if there is a decision that is relevant to your case you may wish to do so. Because ESA is still a relatively new benefit there are very few cases so far. Some Incapacity Benefit decisions may be relevant.

Commissioner's decisions arise when someone appeals against a First Tier tribunal decision. A commissioner will either support the tribunal's decision or make a new ruling that subsequent tribunals will have to take into account.

Commissioner decisions are not binding on other commissioners so you may find conflicting decisions exist and the tribunal will have to decide which one to follow.

You can find commissioner's decisions that may be useful at www.osspsc.gov.uk/Aspx/default.aspx and www.disabilityalliance.org

If you do decide to use a commissioner's decision make sure you read it all to ensure that it is wholly supportive.

At the hearing

You do have a better chance of success if you attend, so we would advise you to go if you possibly can. If you are not able to go, we would suggest that you write explaining why and also submit a written account of your case. In some cases tribunals can be held in your home (this is called a domiciliary hearing). If you request a domiciliary hearing you will need to include a letter from your GP stating that you are unable to travel at all, even by taxi. You may have to wait longer if you ask for a domiciliary hearing.

The tribunal is independent and prior to the hearing they will have received all the paperwork about your case that you were also sent. This is all they know about you at this point.

At the hearing you will usually be greeted by the clerk to the tribunal. The clerk may be in the room whilst your appeal is being heard but they are there in an administrative function only and are not part of the decision making process. The actual panel is composed of a legally qualified Judge, a doctor and someone who has experience of disabled people. Sometimes a presenting officer will also be there; they are from the DWP and are there to explain why the original decision was made. In practice it is quite rare for the DWP to send a presenting officer along.

The Judge will welcome you and introduce everyone present and explain why they are there. You will usually find that you are sitting around a table and hopefully you will be made to feel at ease.

Tribunals vary in the way that they are conducted but generally, even if you have a representative, it will be you that the tribunal will want to question. Your representative will sometimes be able to put your case forward at the beginning of the hearing or may do so at the end. They will also be able to prompt you and ask you questions if they feel that you have

omitted information that is important. It is worth talking to your representative about how they usually work at the hearing and what to expect as there are variations in the way representatives work and Judges conduct hearings.

In addition to questioning you, the tribunal panel will also observe you and its members are likely to ask you questions about how you got to the hearing. It would also be a good idea to tell the tribunal panel what kind of a day you are having.

You may have rested for several days before in order to be able to attend and you may wish to tell them about how you will be affected after the hearing.

If you are feeling very unwell on the day you may not be able to express yourself as well as you would like to. In this case you may wish to explain that you may have problems with concentration and may be too exhausted and unwell to answer fully. If you feel like this, having a representative or someone else with you can be a big help as they will hopefully be able to fill in the gaps. It is a good idea to take a list of all the points you wish to raise so you can make sure you have covered everything.

Once members of the panel have collected all the information that they need you will be asked to leave the room while they make their decision. Usually you will be called back in and given the decision on the day; sometimes the tribunal will not be able to reach a decision on the day and will write to you informing you of the decision a few days later.

What to do if your appeal is not successful

If you are not happy with the outcome of the hearing you have two choices:

- 1 You can ask for a set aside. The First Tier tribunal can set aside a decision when they think it is in the interests of justice to do so. Set asides may be granted in situations where a document that was relevant to the appeal was not seen by one of more of the parties involved in the proceedings, or a party to the proceedings was not present or some other procedural irregularity has occurred.
- 2 You can appeal to the Upper Tribunal. This must be on the grounds that the first tier tribunal made an error of law. Errors of law could include such things as the tribunal failing to apply the law correctly, or the evidence does not support the decision or the tribunal has failed to give adequate reasons for the decision. If you wish to appeal to the Upper Tribunal the first step is to ask the tribunal service for a *Statement of reasons* for the decision. You need to request this within a month of the date of the hearing.

We would advise you to seek further advice if your appeal is not successful and you wish to consider either of the above options. Be aware that there are strict time limits for asking for a set aside or appealing to the Upper Tribunal so you must act quickly.

Revision and appeals checklist

While advice is available through Action for M.E.'s welfare rights line, we do not have the resources to represent our members at tribunals. It is therefore extremely important to try and find a welfare rights representative (see useful contacts on p 13) who is willing to attend the tribunal with you.

It is becoming increasingly difficult to find representation, although it is still worth trying. You may find someone who can assist you in preparing your case even if they cannot attend on the day and this is still valuable. Some organisations can provide you with what is called a written submission that presents your case.

We recommend that, in addition to trying to find a representative to support you, you always do the following:

- Contact the DWP and ask for a copy of the ATOS medical report if there is one. You can also ask for any other medical evidence that has been used in your case. If you have not kept a copy of your DLA form you can request one now.
- Start a diary that will highlight problems that you experience in relationship to the tasks mentioned within the DLA form. Focus on problems with walking and self care.
- Ideally you should obtain medical evidence from an experienced M.E./CFS consultant. The evidence should be based on a recent consultation and highlight the level of your disability and explain your mobility and care needs.
- Your doctor may be able to provide an additional letter to help support your case.
- Supportive letters from other professionals who are currently, or have recently been, involved with your care may be useful. For example, if you have had a social services assessment for community care the social worker involved might agree to write a letter of support.
- Study the information provided by the DWP carefully, especially the doctor's report as you may need to dispute it or point out misunderstandings.
- It is advisable to attend your appeal in person if you are able to, rather than have a paper hearing. If you are unable to attend the appeal because you are very severely disabled you can ask for your tribunal to be held in your own home. This is called a domiciliary hearing. The tribunals service do not agree to this often and you may have a long wait for the hearing if you need this. You will need your doctor's support to enable this to happen.

Useful contacts

Action for M.E.

Information and support for people with M.E. and their carers

General enquiries: 0117 927 9551 (Mon-Fri 9am-5pm)

Enquiries email: admin@actionforme.org.uk

Welfare Rights Line: 0800 138 6544 (times vary)

Online M.E. Centre: www.actionforme.org.uk

Citizens Advice Bureau

Offers advice on a range of issues and may complete a benefits check for you

www.citizensadvice.org.uk

Civil Legal Advice

Help with some benefit appeals for eligible people.

www.gov.uk/civil-legal-advice

Disability Law Service

Offers information and advice on a range of issues including Welfare rights

Tel: 020 7791 9800

www.dls.org.uk

Disability Information and Advice Line (DIAL)

To find your local DIAL office, contact Scope, 6 Market Road, London N7 9PW

Tel: 0808 800 3333

www.scope.org.uk/help-and-information/dial-groups

Disability Rights UK

Factsheets on benefits, tax credits and independent living

www.disabilityrightsuk.org

Local councils

Some local councils employ welfare rights workers. The council may also have information about other services that offer welfare rights advice in your area.

www.gov.uk/find-your-local-council

If you have found the information in this factsheet helpful, please consider making a donation to Action for M.E. at www.actionforme.org.uk or by calling 0845 123 2380 or 0117 927 9551. Thank you.

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Disclaimer Welfare benefits law is complex and subject to change. Information is correct at the time of writing. While every care has been taken to ensure accuracy at the time of writing, this fact sheet can only be a general guide as the process will vary depending on the severity of the claimant's condition. Action for M.E. cannot accept responsibility for any loss experienced as a result of this document.

Appendix I: DLA summary and qualifying criteria

Disability Living Allowance (DLA) is a tax free cash benefit paid to people with disabilities/illnesses which you need to claim before your 65th birthday. If you qualify you can continue to be paid beyond your 65th birthday. It is a non means-tested benefit and is paid on top of earnings and other Social Security benefits. It is a non-contributory benefit and therefore does not depend on National Insurance Contributions.

To qualify you must have been disabled/sick for three months and likely to remain so for at least six months. There are two components to DLA: the **mobility** component (paid to those with walking difficulties) and the **care** component (paid to those with personal care needs). Either one or both of these components can be paid based on an assessment of your needs.

Mobility component

<i>Rate</i>	<i>Disability tests</i>
Lowest	This is payable if you are able to walk but you are so severely physically or mentally disabled that you cannot walk on unfamiliar routes without guidance or supervision from another person most of the time.
Highest	Payable if a person: <ol style="list-style-type: none">1 is unable to walk or virtually unable to walk* or2 has to exert themselves to walk to such an extent that it would constitute a danger to life or would be likely to lead to a serious deterioration in health or3 has had both legs amputated at or above the ankle or4 was born without legs or feet or5 is both deaf and blind and needs someone with them outdoors or6 is severely mentally impaired, displays severe behavioural problems and qualifies for the highest rate care component for day and night-time needs.

*According to regulation 12 (1)(a)(ii) DLA, 'virtually unable to walk' means: "your ability to walk out of doors is so limited with regards to distance, speed, length of time, manner in which you can make progress on foot without severe discomfort that you are virtually unable to walk." This is the disability test most people with M.E. qualify under.

The walking problems for DLA higher rate mobility must be physical. A Commissioners' decision on 12 February 1998 concluded that M.E./CFS is "physical in origin."

When assessing your ability to walk you need to be very clear on:

- the **distance you can walk** before you suffer from severe discomfort; it is advisable to measure the distance before you fill in this part of the form
- the **length of time it takes to recover** before you feel able to walk again without severe discomfort
- the **speed you can walk at**; it is useful to time yourself and make notes of fluctuations.
- the **manner in which you walk**; this refers to the things such as balance, posture, movement and range of movement in your joints.

Care component

Rate *Disability tests*

Lowest Needs attention with bodily functions* for a significant portion of the day, or is aged 16 years or over and unable to prepare a cooked main meal, for yourself, if you have all of the ingredients. This does not include snacks or convenience foods. It is referred to as the 'cooking test'.

Middle Payable if a person:

- 1 needs frequent attention with bodily functions throughout the day **or**
- 2 needs continual supervision throughout the day to avoid substantial danger to themselves or others **or**
- 3 needs prolonged or repeated attention at night in connection with bodily functions **or**
- 4 needs someone to be awake during the night for a prolonged period of time or at frequent intervals, in order to avoid substantial danger to themselves or others.

Highest Payable if:

- 1 one of the middle-rate daytime conditions (1 or 2 above) and one of the middle-rate night time conditions (3 or 4 above) are satisfied **or**
- 2 life expectancy is limited to six months because of an illness.

*The expression 'bodily functions' was defined by the Court of Appeal in 1981 as including "breathing, hearing, seeing, eating, drinking, walking, sitting, sleeping, getting in or out of bed, dressing, undressing, eliminating waste products and the like, all of which an ordinary person who is not suffering from any disability does for himself. But they do not include cooking, shopping, or any of the other things which generally one of the household does for the rest of the family."

There is also help from the Courts on the meaning of 'need' or 'require.. It was at one time argued that the only help that qualified was that needed for medical purposes, to keep body and soul together, but in 1997 the House of Lords held that "[the test to be applied in all cases is] whether the attention is reasonably required to enable the severely disabled person as far as reasonably possible to live a normal life."

So if, for instance, you would go to social events if only you had someone to drive you there and push your wheelchair, these count as care required in connection with a bodily function (walking). Remember that if you are claiming the high rate mobility component that the walking tests still apply.

Appendix II: example of initial appeal letter

This is just to give you an idea of the type of information that you could provide. You will need to adapt it to reflect your own situation and you may wish to include examples and cross reference with your claim form.

If you do not receive an acknowledgement within 14 days, phone and make sure that your appeal has been received.

I am appealing against the decision that I am not entitled to DLA. I do not think that the full impact of my condition has been taken into account. M.E affects all areas of my life and restricts me in many ways.

As described on my claim form I experience debilitating exhaustion which includes both physical and mental fatigue, as well as many other symptoms, such as pain, aching muscles, cognitive problems, frequent sore throats and flu like symptoms, dizziness and muscle weakness etc. These combined symptoms affect my mobility and my ability to self-care.

I think that I meet the criteria for high rate mobility as my walking is restricted to less than 50 metres before the onset of severe discomfort. Many days I am too unwell to leave the house at all and am confined to bed or the sofa. On other days I can walk about 30-40 metres but am in pain when walking and I have to rest afterwards.

I am not able to cook a main meal for myself as most days I feel too unwell and exhausted to set about this. I cannot stand or sit to prepare food for cooking due to overwhelming fatigue. I often feel nauseous and dizzy so handling food and hot pans is just not possible and can put me at risk as I may drop hot pans or cut myself. My concentration is poor and I am no longer able to follow a recipe and get timings right.

Please send me all the information that was used when making this decision including any medical reports that were used. I will be sending in further information to support my appeal once I have had the opportunity to consider all the evidence.

Appendix II: Commissioner's decisions

Below are a few decisions that give an idea of how the law may be interpreted when assessing DLA claims. The ones listed all have relevance to people with M.E. Generally, it is not necessary to use Commissioners decisions when making an appeal but looking at them gives an idea of how the law has been applied.

If you are at Tribunal stage, careful study of your paperwork will give some indication of whether or not these decisions will help your case. Ideally, you will discuss these with your tribunal representative who may be aware of other decisions that may help with your case.

Please note that the Commissioners Decisions mentioned are applicable at the time of the publication of this information sheet and that other decisions taken may override these in due course.

You can usually search for these decisions by putting the reference into a search engine e.g CDLA/265/97 and in some cases you will then be able to access the whole decision. In other cases the whole decision may not be available but is included here to give you an idea of the way the law has been interpreted.

Higher rate mobility component. Whether M.E./CFS is a physical disability. CSDL4/265/97 Commissioner Walker, 12 February 1998

The claimant was originally awarded the high rate of mobility and the middle rate of the care component of DLA. When the claimant renewed the application both components were disallowed. A tribunal reinstated the middle rate care component, but the mobility component was refused on the basis that "the complainant's mobility problems were not caused by physical factors", the issue before the Commissioner was whether the origin of the condition, i.e.. Chronic Fatigue Syndrome amounted to a physical disability for the purposes of SECTION 73 (1) (a) SSCBA 1992.

Held, The appeal was allowed and submitted to a new tribunal. The new tribunal were directed to take into account all of the medical evidence to determine whether the claimants condition was caused by a physical disability. It was also directed to take account of REG 12(I)(a)(ii) SS (DLA) REGS 1991 and whether the 'virtual' inability to walk was caused by 'mental, illusory, or imaginary' factors or not.

The Commissioner concluded that the causes of CFS appear to be regarded as organic and, therefore physical in origin. CDLA/1954/95 also considered. When the new tribunal heard this case, the claimant won.

Severe discomfort

R(DLA)4/98 (formerly CDLA/12940/96) differentiates between pain and discomfort. Pain encompasses a wide range of intensities from mild to severe. Discomfort defined according to the dictionary as "the condition of being uncomfortable; uneasiness". So someone in pain may not be suffering severe discomfort but a claimant may suffer severe discomfort without

pain e.g. breathlessness (see also R(M)1/83). However someone in severe pain does suffer severe discomfort.

R(M)1/81 states that severe discomfort being a lower concomitant of severe pain; doesn't mean "excruciating agony" and CM/1/1981 states that severe discomfort includes pain, fatigue and unease of all kinds.

Time taken to recover from walking

CDLA/805/1994 gave a hypothetical example where a tribunal could conclude that someone who could walk 400 yards but who then had to wait for two hours before walking another 400 yards was virtually unable to walk.

Cooking test

R(DLA)2/95 (Formerly CDLA/85/1994) defines the "cooked main meal" as a labour intensive reasonable main meal freshly cooked and prepared on a daily basis on a traditional cooker for one person. Reasonable is what is reasonable for a member of the community to which the claimant belongs eg. a vegetarian but a "cooked main meal" is not a snack. The test includes all activities associated with cooking such as reaching for a saucepan, lifting it and filling it with water.

"Prepare" includes peeling and chopping. Because the test is objective it is irrelevant that a claimant may never wish to cook such a meal or that it is considered financially impossible. CDLA/2267/1995 states that the meal is a main meal for one person. Heavy pans or dishes are not necessary when preparing this meal.

Appendix IV: DWP Medical guidance for Decision Makers

This section is reproduced from the A-Z of medical conditions, part of the DWP Medical guidance for Decision Makers. **It is not the property of Action for M.E.**

It is the resource that Decision makers at the DWP will consult about medical conditions and can be found on the DWP website at www.dwp.gov.uk/publications/specialist-guides/medical-conditions/a-z-of-medical-conditions/chronic-fatigue-syndrome

It was updated in June 2013.

What you need to know about Chronic Fatigue Syndrome (CFS)/Myalgic Encephalomyelitis (M.E.)

Chronic fatigue syndrome (CFS) causes persistent fatigue (exhaustion) that affects everyday life and doesn't go away with sleep or rest. Read more at NHS Choices at www.nhs.uk/conditions/chronic-fatigue-syndrome/pages/introduction.aspx

What evidence is available?

Useful sources of further evidence include:

Hospital Reports

National Health Service hospitals and trusts are required by the NHS Executive to provide factual reports incidental to the claimant's treatment when requested by the Benefits Agency. The hospitals or their employees are not paid on an individual basis for the reports. It is the responsibility of the hospital or trust management to ensure that the information is supplied.

Although patients are under the care of a designated consultant, this doctor does not necessarily have to complete the report. An alternative member of the medical team, another consultant or other healthcare professional may carry out the task.

The hospital report will contain information obtained from the medical records and the professional's knowledge of the patient. It will consist of detail relating to diagnosis, special tests, clinical findings, medication etc.

A hospital doctor will not have the background knowledge to answer specific questions relating to the criteria for benefit entitlement.

Hospitals are likely to be the most appropriate source of information when the medical diagnosis is uncommon or treatment is very specialised.

Physiotherapists

A physiotherapist has expertise in preventing and treating diseases/disabilities, particularly in relation to the neuromuscular, musculoskeletal, cardiovascular and respiratory systems.

Physiotherapists have a major contribution to make in restoring independence after a traumatic incident such as a stroke or head injury, after major surgery such as amputation, joint replacement or organ removal.

They also provide treatment for muscle, ligament, or tendon injuries, spinal conditions and rehabilitation after fractures.

When a physiotherapist treats a person for a minor illness/injury e.g. ankle injury or mechanical low back pain, the course of treatment is relatively short-lived involving two to six sessions over a similar number of weeks. Treatment after a major surgery e.g. joint replacement or amputation will be more prolonged but will be finite in length.

A few long-term disabilities may require continuing treatment on a regular basis, but this is not frequently the case. In these situations the patient may be able to carry out the exercises themselves or their carer is taught to do the procedure e.g. chest physiotherapy in cystic fibrosis.

Review of posture, pattern of walking and mobility in general is very much part of the role, together with pain-reducing and muscle-strengthening techniques.

Physiotherapists assess patients for and can prescribe appropriate aids. These include walking sticks, crutches, frames and wheelchairs. Other equipment might include TENS machine for pain relief, incontinence aids, splints, neck collars and calipers.

A report from a physiotherapist could be expected to contain a brief medical history, diagnosis of the disabling condition and details of clinical examination and treatment plan.

Information about limb function and ability to walk with appropriate appliances will often be available.

In milder conditions information will relate to a specific episode of treatment relating to the affected area of the body, and the report is unlikely to cover the disabling effects of other generalised conditions.

Occupational Therapists (OTs)

The prime function of OTs is to maximise the independence of the patients through assessing their needs and prompting the restoration of the maximum use of function. As specialists in the provision of disability equipment they offer practical advice on adapting the environment to the needs of the individual.

OTs will be found working in many areas of health care; learning disability, mental illness, geriatrics, physical disability, paediatrics, day care and rehabilitation centres. They work in a variety of settings including hospitals, day centres, claimant's own homes and residential accommodation.

Their work focuses on enabling people to perform every day activities such as washing, dressing, cooking and shopping. They help people to readjust to independent living after discharge from hospital.

Where OTs work with people with mental health disorders or learning disabilities, they prepare these patients to return to as full a life as possible in the community. This may involve psychology or behavioural programmes including group work, for example, desensitisation programmes for agoraphobia or social skills training for people with long-term mental disorders.

Reports from occupational therapists can provide very useful information since they link disability to need.

Sometimes OTs can prove difficult to identify as a source of information, especially if the patient is only seen on one or two occasions before discharge or in their own home.

If an elderly person is assessed at home a copy of the report may be available in his or her general practice records.

Claimants themselves may also have a copy of their assessment report.

General Practitioner Reports (GP Reports)

GPs are the first point of contact for people with a health condition and provide ongoing care to their patients. They are responsible for diagnosing and treating illnesses and may refer the patient to hospital for specialised care, in which case a report is usually sent back to the GP. GPs will have long term knowledge of the patient and hold the patient's records including hospital correspondence. GPs generally are not trained and do not assess a patient's function and are therefore not usually in a position to give information about their patients' ability to perform daily living activities.

It is reasonable to expect a GP's report to contain factual information such as diagnosis, history of the condition, clinical findings, results of special tests, medication and treatment plan.

The GP may have very limited information on people who have had stable, long-term disabilities, often since childhood, for example children and adults with learning disabilities. Claimants with mental health problems or learning disabilities may be mainly under the care of community psychiatric services or other specialist teams and it is often more appropriate to make an initial request for a factual report from another agency or professional.

Health Care Professional (HCP) examination Reports

A HCP is a practitioner involved with patient care. This would include doctors, nurses, occupational therapists and physiotherapists. They will have received training in disability assessment medicine. In addition they are instructed in the assessment of care and mobility needs relating to the entitlement to DLA/AA.

A HCP examination report will provide details of the diagnosis (where known), brief history of the condition, treatment, a record of clinical examination, severity and likely disabling effects of the condition on day-to-day living.

The HCP examination report is able to provide a critical appraisal of whether a person's claimed care and mobility needs are reasonable in the light of the disabling condition(s).

A HCP examination report can be particularly helpful in situations where the existing medical evidence (usually factual reports) appear to be contradictory, or where factual reports do not appear to cover areas relevant to entitlement.

When the Decision Maker decides to request a HCP examination report, it is worth considering the exact nature of the information required and to formulate a submission with some specific questions for the HCP. It may also be useful to enclose copies of factual reports, especially if existing evidence is contradictory.

Activities of Daily Living and Mobility needs

The disabling effects of CFS/M.E. in individuals is variable. The following describes the typical problems with daily living activities for the majority of the time.

Mild functional restriction

<i>Category</i>	<i>Description</i>
Mobility	The ability to walk long distances may be reduced, but the person is likely to be able to walk short distances on an unrestricted basis most of the time. Their judgment, thought processes and means of communicating are not affected to the extent that they would be unable to find their way around in familiar and unfamiliar places.
Care	The person would normally to be able to wash, dress, bathe, use the toilet, get up and downstairs without difficulty. The ability to plan a meal is not impaired and the tasks involving in preparing and cooking food are unlikely to be restricted in any way.

Moderate functional restriction

<i>Category</i>	<i>Description</i>
Mobility	The ability to walk more than 100 metres consistently may be restricted in moderate cases, but severe restriction of walking is unlikely. Their judgment, thought processes and means of communicating are not affected to the extent that they would be unable to find their way around in familiar and unfamiliar places.

Care	Those with a moderate level of functional restriction would be expected to be able to manage some personal care and preparation of food without help from another person most of the time. Tasks may take longer than normal and may need to be followed by a period of rest. Although the level of fatigue and symptom severity may vary during the day or from day to day, the ability to maintain personal hygiene and nutrition is likely to be unimpaired.
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Severe functional restriction

<i>Category</i>	<i>Description</i>
Mobility	Such claimants may be severely restricted in their ability to walk. There may be a requirement for supervision either at home or out of doors as a result of significant cognitive impairment, but it would be uncommon.
Care	People with a severe level of functional restriction, who spend most of the day in bed or otherwise immobile, and who may have clinically evident muscle wasting, may well need help with personal care and preparing food.

Prognosis and duration of disabling effects

People with mild illness may recover spontaneously, or with some general advice or a limited treatment programme over the course of the following six months. These people are likely to be treated in a general practice setting.

People with established CFS/M.E. of moderate severity lasting one to two years or more are likely to need a more extensive management programme, as described above, lasting 6 to 12 months or more. Most people who are able to attend hospital for treatment are likely to make a significant improvement with appropriate management. Some people will recover fully, but others will not achieve their previous level of functioning. Some may not improve. Those who recover may be at risk of recurrence. Those who improve are at risk of relapse. In many patients, disability and quality of life can be improved, sometimes to a significant extent. Severe cases are less likely to recover completely or benefit substantially from a management programme.

Indicators of a good prognosis are:

- male sex
- a definite history of an acute viral illness like glandular fever at the onset
- mild disability and few symptoms
- clinical features showing a pattern of evolution towards functional recovery
- early diagnosis aimed at eliminating associated physical disorders and/or identifying psychiatric illness along with other complicating psychological or social factors

- a management approach which may encompass physical, psychological and social elements that allows a stepwise approach to functional improvement using rehabilitation.

Indicators of a poor prognosis are:

- onset of symptoms without any clear precipitating factor
- clinical features characterised by severe and unremitting symptoms
- severe and persistent disability
- a management approach that overemphasises the importance of either complete rest or which advocates a rapid return to pre-illness levels of physical activity
- those with co-morbid significant medical conditions or mood disorders
- a complex background of adverse psychological and social factors.

All information must be taken into account when considering the duration of disabling effects and the duration of disabling effects must be based on the particular circumstances of the individual claimant.

