Department for Work & Pensions

Government Social Research

Specialism in the Health Assessment: Initial Exploratory Research

(October 2024)

DWP research report no. 95

A report of research carried out by Basis Social on behalf of the Department for Work and Pensions.

This document/publication is also available on our website at: https://www.gov.uk/government/organisations/department-for-work-pensions/about/research#research-and-analysis-publications

If you would like to know more about DWP research, email socialresearch@dwp.gov.uk

First published October 2024.

ISBN 978-1-78659-717-5

and Pensions or any other government department.

Executive summary

In 2022, the Department for Work and Pensions (DWP) commissioned Basis Social, an independent research agency, to carry out research with health and disability benefit claimants to understand how the use of specialism in health assessments may improve the assessment process. This research was commissioned to provide DWP with evidence of the potential impact different forms of specialist intervention may have on claimants' experience of assessment processes. In this research, specialism is defined, in the broad sense, as Healthcare Professionals (HCPs) who can use targeted skills and knowledge around a specific condition group because of their professional background or training provided by DWP. It is important to note, that although the term 'specialist' is referenced throughout this report, at the time of publication, the term 'specialist' is no longer used to refer to assessors in the context of Personal Independence Payment (PIP).

The research comprised of 30 participants taking part in one-hour, online in-depth interviews which included participants listening to, discussing, and comparing two, partial, mock assessments. All participants were in receipt of PIP and/or Universal Credit/Employment and Support Allowance (UC/ESA) and had been through a disability benefit assessment process in the past twelve months. The sample was selected across three health condition areas: 'think and feel differently' (including mental health needs, learning difficulties), 'sense differently' (including blind and partially sighted individuals) and 'other' (including complex health challenges, chronic pain). The mock assessments explored four types of specialism: static resource (e.g. case studies, handbooks), specialist support (e.g. HCPs with condition focussed experience available to provide advice), specialist HCP training, and recruited specialists (e.g. HCP specialists from NHS).

Overall, the interviews showed that participants were, generally, in favour of specialisation. Participants highlighted the importance of feeling understood, listened to and supported by their assessor, and being able to freely discuss the complexities of their individual case. Specialism was viewed as a way of improving the assessor's ability to understand health conditions and their functional impacts on daily life. Similarly, greater specialism led participants to report that they would feel more at ease during their health assessments, as it helped build trust and confidence.

In some cases, participants reported that they would be willing to wait longer in order to be matched with a specialist. Moreover, some participants were willing to compromise on the mode in which the assessment was conducted to guarantee being seen by a specialist, for example having an online or telephone assessment instead of face-to-face. In general, participants showed preference for online or telephone assessments, however, this was dependent on the type of health condition the participant had. For instance, mobility conditions were believed to be better suited for in-person assessments as it was felt that it was important for the assessor to see how the condition presents in real life.

Knowing the assessor was an HCP with years of experience and had reviewed and understood their case was satisfying for participants. It was also viewed positively when assessors introduced their specialism at the start of the health assessment. Although this was seen to build rapport, when the assessor's specialism was over-emphasised, it had a negative impact, with some participants doubting the assessor's credibility and ability to individualise the assessment.

The positive findings regarding the assessment introduction demonstrates that there are alternative routes that can be taken to improve claimant confidence in health assessments, beyond explicitly matching claimants to assessors with condition specific skills and backgrounds.

Contents

Background

In 2022, DWP commissioned Basis Social, an independent research agency, to carry out research with health and disability benefit claimants to understand how the use of specialism in health assessments may improve the assessment process. For the purposes of this research, the term 'claimants' refers to individuals with previous experience with DWP health assessments.

Ahead of 'Transforming Support: The Health and Disability White Paper'[1], there had been external engagement with DWP through the Green Paper consultation[2] regarding the option for a claimant to request a specialist assessor for their health assessment. DWP wanted to understand if there are circumstances where it could be beneficial to bring in additional expertise to support assessors and decision-makers, and if access to an assessor with condition focussed training or experience would increase people's trust in the health and disability benefits system as well as satisfaction with the assessment process. It is important to note, that although the term 'specialist' is referenced throughout this report, at the time of publication, the term 'specialist' is no longer used to refer to assessors in the context of Personal Independence Payment (PIP).

This research was commissioned to provide DWP with evidence on the potential impact of different forms of specialism interventions on claimant experience of assessment processes.

Research Methods

The research comprised of 30 participants taking part in one-hour, online in-depth interviews in late 2022. All participants were in receipt of PIP and/or UC/ESA and had been through an assessment process in the past twelve months. They were split equally across three health condition areas:

- 'Think and feel differently' (including mental health needs, learning difficulties, neurodiversity, and psychosocial disorders).
- 'Sense differently' (including blind and partially sighted individuals).
- 'Other' (including complex health challenges, chronic pain, facial differences, ageing, short of stature and communication difficulties).

Participants were recruited based on their primary health condition, although some had more than one condition and therefore fell into more than one health condition area. The participant sample comprised of adults who represented a distribution of ages, ethnicities and genders.

During the interviews, participants listened to two out of four, partial, mock assessments that were centred around a health condition relevant to their own health condition area. These mock assessments were approximately four minutes long and

[1] DWP (2023) Transforming Support: The Health and Disability White Paper
[2] DWP (2023) Shaping future support: the health and disability green paper

were recorded using two actors: one as an assessor and one as a claimant. The actor playing the assessor did not have any clinical background. Rather, they followed a script designed to imitate an HCP with this level of specialism in the health condition being assessed. The script followed standardised questions with only contextual information changing to indicate the specialism. The mock assessments varied across the three health condition areas, as well as the following four types of specialism which varied from least to most in depth condition focussed training or experience:

- Static resource: A pool of knowledge to support the assessment and decision making. E.g., case studies, condition guides and handbooks.
- Specialist support: Specialists available to provide advice to non-specialists. These may include registered HCPs with condition focussed training and experience or those with lived experience.
- Specialist HCP training: Provide HCPs with specialist training as part of the DWP led functional assessment training, enabling them to become a specialist in this area.
- Recruited specialists: HCP specialists recruited directly from organisations (for example the NHS).

Participants were asked to note how they would feel going through the mock assessments presented and to discuss what they thought of the process, including how it aligned with their own experiences, what they felt went well or not so well and what they wished could be improved. Participants were also encouraged to compare the two mock assessments and think about possible compromises they would be willing to make for more specialist support during health assessments.

Findings

To note, the findings are contextualised within the illustrative mock assessments presented to participants during the interviews and not genuine health assessments. Additionally, participants only listened to mock assessments that were relevant to their own health condition area.

Prior health assessment experience

The interviews captured an overall feeling that health assessors need to listen, understand and be empathetic towards claimants and their individual cases. It was highlighted during the interviews that participants want to feel understood and treated as a person with an individual set of circumstances. Most participants concurred that during their own previous health assessments, their assessors lacked sufficient empathy and rather than being given the chance to explain their circumstances, they felt they were being tested or as though there were correct and incorrect answers. It was stated that this made the health assessment process challenging, stressful, and as one participant reported, at times “embarrassing”.

The value of specialism

As part of the interview, participants discussed the varying levels of specialisms presented in the mock assessments. In general, participants were in favour of specialisation, particularly when the degree of specialist training and/or experience was greater as this was seen as a way of improving health assessments. Specialism was perceived to improve the assessor's understanding of a health condition and its daily impacts. In turn, this was anticipated to improve the relevance of the questions and prompts used to explore the impact of conditions during the health assessment. This made participants feel they could trust the assessor more and be more confident and satisfied in the assessment outcome. Overall, more specialism, and thus more understanding of conditions, led participants to report that they would feel more at ease during their health assessments.

Claimant compromise

The interviews demonstrated that some participants would be willing to wait longer to have an assessment with a specialist because they felt this would lead to higher quality and fairer assessments. This was particularly the case if benefits were to be backdated in order to offset any financial losses experienced when waiting for a specialist assessor to become available. However, other participants believed wait times are already too long and therefore recommended the idea of having their case re-evaluated by a specialist if necessary. It was recognised that assessors are likely to only be specialised in one condition, so participants stated that they would be satisfied if their assessor was a specialist in, preferably, their primary condition, and only had generalist knowledge in any additional conditions.

To guarantee being seen by a specialist, there was also a willingness to have an assessment online or via the telephone instead of face-to-face. In general, depending on the health condition of the participant, video or telephone assessments were viewed as preferential and video calls were seen as a better way to establish rapport and to create valuable context that could be missed over the phone. For example, blind or partially sighted participants highlighted that in-person health assessments were often challenging due to location. Similarly, participants with mental health conditions, such as generalised anxiety disorder, felt that online assessments relieved some of the stressors that came from being in a setting outside of their home environment. On the other hand, mobility conditions were believed to be better suited for in-person assessments as it was felt that it was crucial for the assessor to see how the condition presents in real life.

Introducing assessor specialism in the health assessment

Overall, participants tended not to realise that all assessors are already qualified HCPs. Participants communicated that being informed about their assessor's qualifications and their preparedness for the assessment would enhance their overall confidence in the process. Knowing their assessor had years of experience working in their condition specific field was considered valuable as they felt the assessor

would understand their condition and be more empathetic towards their circumstances.

Having the assessor explicitly share their specialism in the mock assessment introduction was also viewed positively by participants as it was seen to build rapport. Participants conveyed that it made the assessment questions seem more relevant as it demonstrated the assessor was prepared and likely to understand the condition and specific case to a greater extent.

Limitations of the value of specialism

In the mock assessments, when the specialism was frequently referenced to following the initial introduction, participants highlighted how they began to doubt the value of it. By over-emphasising the specialism, participants felt the assessor had predetermined beliefs about the claimant which inhibited the claimant's ability to share their personal experiences. Frequent reference to qualifications or specialism in the mock assessment was additionally viewed as unusual, and particularly for those with anxiety, it led to second-guessing the credibility of the assessor's experience.

Regarding the specific types of specialisms explored in the mock assessment, participants highlighted reservations about each type of resource:

- For **static resources**, it was seen that all assessors should have access to this type of information and continually referring to the resources would undermine the assessor's credibility and limit the scope for assessing individuality of cases.
- For **specialist support**, it was similarly seen to undermine the assessor's credibility and capability of carrying out the assessment. It led participants to question why the specialist support was not able to carry out the assessment themselves.
- For **specialist training**, participants expressed concern on the depth and rigour of the content and expressed unease as to who was facilitating the learning.
- For **recruited specialists**, the notion of having a specialist consultant conduct the health assessment was deemed as potentially intimidating. Participants expressed a fear of saying the wrong thing and not receiving an award.

Concerns regarding the practicality of recruitment were also referenced by participants, as it was felt that individuals who are specialists in their field, would be time poor and already in other employment.

Conclusion

The purpose of this research was to provide DWP with evidence on the potential impact of involving different forms of specialism interventions on experience of assessment processes.

Overall, the research showed that participants want to feel they are being understood, listened to and supported by their assessor, and able to freely discuss the complexities of their individual case. Specialism was viewed as a way of

improving the assessor's ability to understand health conditions and its functional impacts on daily life, as well as building trust and confidence. As such, participants felt satisfied knowing that their assessor was an HCP with years of experience, had reviewed and understood their case and was able to facilitate an open conversation during the assessment.

Being introduced as a specialist was viewed as a positive way to build rapport in the assessment, however, when it was over-emphasised, it was considered to be counterproductive as participants began doubting the assessor's credibility and ability to individualise the assessment.

The positive findings regarding the assessment introduction demonstrates that there are alternative routes that can be taken to improve claimant confidence in health assessments, beyond explicitly matching claimants to assessors with condition specific skills and backgrounds.