Training Qualifications UK

Part of the AQA group

Alternative Academic Qualifications

Qualification Specification

TQUK Level 3 Alternative Academic Qualification in Health and Social Care (Extended Certificate) (RQF)

Qualification Number: 610/5497/5

Version DV2

Contents

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Summary of changes

The following table provides a summary of the changes that have been made to the qualification specification since the publication of the previous version.

Version number	Summary of changes
DVI	Please note that this is a draft version of the qualification specification and is subject to further review and updates. The final version will be published once the qualification is live.

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Introduction

Welcome to TQUK

Training Qualifications UK (TQUK) is an Awarding Organisation recognised by the Office of Qualifications and Examinations Regulation (Ofqual) in England and CCEA Regulation in Northern Ireland.

TQUK offers qualifications which are regulated by Ofqual and, in some cases, by CCEA Regulation. All regulated TQUK qualifications sit on the Regulated Qualifications Framework (RQF) and are listed on the Register of Regulated Qualifications.

Qualifications offered by TQUK are designed to support and encourage learners in developing their knowledge and skills. These qualifications may lead to further study or support progression into higher education. TQUK qualifications also provide opportunities to progress to further qualifications. The TQUK website provides news and updates on upcoming developments.

Centre Recognition

To offer any TQUK qualification a centre must be recognised by TQUK.

The TQUK centre recognition process requires a centre to have in place a number of policies and procedures to protect learners undertaking a TQUK qualification and the integrity of TQUK's qualifications. These policies and procedures will also support a recognised centre's quality systems and help the centre meet the qualification approval criteria.

Recognised centres must seek approval for each qualification they wish to offer.

The approval process requires centres to demonstrate that they have sufficient resources, including suitably qualified and occupationally competent staff to deliver, assess, and quality assure the qualification. Centres must also have access to appropriate support in the form of specialist resources. Qualification approval must be confirmed prior to any assessment of learners taking place.

Qualification Specifications

Each qualification offered by TQUK is supported by a specification that includes all the information required by a centre to deliver the qualification. The specification provides mandatory teaching content and assessment details.

The aim of the qualification specification is to guide centres through the process of delivering the qualification.

It is recommended that centres read the qualification specification alongside the documents listed in the mandatory documents section on page 18. TQUK's procedures and policies can be found on the website.

Qualification specifications are also available on the website. If you have any further questions, please contact TQUK for assistance.

Centres must ensure they are using the most recent version of the qualification specification for planning and delivery purposes.

Reproduction of this document

Centres may reproduce the qualification specification for internal use onlybut are not permitted to make any changes or manipulate the content in any form.

Centres must ensure they use the most up-to-date pdf version of the specification.

Use of TQUK Logo, Name and Qualifications

TQUK is a professional organisation and the use of its name and logo is restricted. TQUK's name may only be used by recognised centres to promote TQUK qualifications. Recognised centres may use the logo for promotional materials such as corporate/business letterheads, pages of the centre's website relating to TQUK qualifications, printed brochures, leaflets, or exhibition stands.

When using TQUK's logo, there must be no changes or amendments made to it, in terms of colour, size, border or shading. The logo must only be used in a way that easily identifies it as TQUK's logo. Any representation of TQUK's logo must be a true representation of the logo.

It is the responsibility of the centre to monitor the use and marketing of TQUK's logos and qualifications on their materials, as well as on those of any resellers or third parties they may use. TQUK must be made aware of any centre relationships with resellers of TQUK qualifications. TQUK must be made aware of any additional websites where the centre intends to use TQUK's name and/or logo. If this information is changed, TQUK should be notified immediately. TQUK is required to monitor centres' websites and materials to ensure that learners are not being misled.

If a centre ceases to be/surrenders recognition as a TQUK centre, it must immediately discontinue the use of TQUK's logo, name, and qualifications from all websites and documents.

Accessibility

TQUK is committed to ensuring that all qualifications and assessments are accessible, inclusive, and non-discriminatory. We ensure that no aspect of this qualification disadvantages any group of learners

who share a protected characteristic or introduces unjustifiable barriers to entry, other than those essential to the qualification's intended purpose. Where such features are necessary, they will be clearly stated and justified.

All assessment design processes actively identify and remove unjustifiable barriers that could prevent learners, including those with physical disabilities, from demonstrating their knowledge, understanding, or skills. TQUK monitors and reviews the nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation) throughout qualification development to maintain accessibility and inclusivity. This approach promotes positive attitudes and fosters good relations among all learners.

More information can be found in our Equality and Diversity Policy.

For learners seeking guidance on Reasonable Adjustments, please see our Reasonable Adjustment Policy.

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Section 1: Qualification Essentials

The Qualification

Alternative Academic Qualifications (AAQs) are associated with specific subject area routes and have been designed to meet the requirements set by the Department for Education (DfE) following the level 3 educational reforms.

The primary purpose of this qualification is to support learners to progress into higher education.

The TQUK Level 3 Alternative Academic Qualification in Health and Social Care (Extended Certificate) (RQF) is regulated by Ofqual and is equivalent to one A Level.

In a typical study programme where an AAQ is studied alongside two A Levels, this qualification is designed to be delivered over two years.

Qualification Purpose

The purpose of the AAQ in Health and Social Care is to provide learners with the knowledge and skills necessary to progress to higher education and ultimately work within the health and social care sector.

Alternative Academic Qualifications (AAQs) have been approved by the Department for Education (DfE) and are allocated UCAS tariff points. An AAQ Extended Certificate is 360 guided learning hours, equivalent to one A Level and will complement a traditional A Level route. When combined with A Levels as part of a mixed-study programme, AAQs provide learners with a high-quality entry route into higher education.

It provides learners with a strong foundation of knowledge and skills in health and social care principles that complement theoretical concepts covered in the A Level curriculum. This integrated approach will enable learners to gain a full understanding of academic principles and their practical application. This will, in turn, showcase their ability to apply concepts and techniques and strengthen their university/college applications, giving them a competitive edge.

Learners will develop knowledge, understanding and skills in areas such as understanding and complying with regulatory requirements; promoting health and safety practices, conducting risk assessments, implementing effective infection control and prevention measures, safeguarding adults at risk, practising inclusivity, delivering person-centred care, maintaining accurate records, and engaging in continuing professional development.

By undertaking this Extended Certificate, learners will acquire a diverse set of skills that can be effectively applied to higher education studies. The qualification's breadth ensures that learners develop transferable skills that are relevant for pursuing higher-level studies. These skills encompass a broad range of areas and can be utilised across various disciplines and fields of study.

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Entry Requirements

There are no formal entry requirements, however, learners should have a minimum of a level two in literacy and numeracy or equivalent.

Although TQUK does not require learners to have prior subject knowledge before registering on the AAQ, having a foundational understanding would support their progress.

Entry to the qualification is at the centre's discretion.

The recommended minimum age for this qualification is 16 years.

What Will The Learner Study as Part of This Qualification?

Learners will explore the fundamental principles of working in the health and social care sector, including the roles and responsibilities of professionals, effective communication, and the importance of ongoing professional development. They will examine key legislation relevant to the sector and how legal and regulatory requirements shape best practice.

Learners will also examine health and safety concerns, the measures required to maintain a safe working environment, and the strategies used to ensure effective infection control. They will gain an understanding of safeguarding, including recognising the signs of abuse or neglect and the appropriate reporting mechanisms to follow when concerns are raised.

Additionally, learners will consider the significance of equality, diversity, and inclusion and how these principles shape practice. They will develop an understanding of person-centred care, exploring its role in meeting individual needs, promoting dignity, and ensuring high-quality support of the individual.

What Knowledge and Skills Will The Learner Develop as Part of This Qualification?

The qualification is designed to provide learners with a strong, academic and transferable skillset essential for studying at a higher level. Throughout the AAQ, learners will have the opportunity to develop written and verbal communication skills, proficiency in academic writing, critical thinking and analysis, time management skills, and the ability to carry out independent research.

These skills closely align with university expectations and will ensure that the learners are prepared for the rigour of higher-level study, where they will be able to utilise them at an advanced level.

Which A Level Subjects Will Complement This Qualification?

The A Level subject areas that will complement the qualification include:

- Biology
- Chemistry
- English Language
- Law

- Mathematics
- Physical Education
- Physics
- Psychology
- Sociology.

Which Higher Education Courses Can This AAQ Lead To?

This qualification has been designed to support progression to higher education. It may support entry to a range of degree programmes including:

- Community Specialist Practice
- Health and Care Management
- Health and Social Care
- Healthcare Science
- Health, Nutrition, and Lifestyle
- Professional Practice
- Paramedic
- Dentistry
- Medicine
- Counselling.

UCAS Tariff Points

The qualification will attract UCAS Tariff Points, helping learners progress to higher education. The number of tariff points awarded will depend on the final grade achieved.

The tariff points assigned to this qualification are outlined in the following table:

Grade	UCAS Tariff Points
D*	56
D	48
M	32
P	16

Further details may be found on the UCAS website, where learners can also use the Tariff Calculator to estimate their overall predicted grades for this AAQ and A Levels.

Learners should be encouraged to verify individual university entry requirements by visiting the university's website, referring to their admission policies, or contacting their admissions team directly.

Structure and Assessment Approach

Structure

The TQUK Level 3 Alternative Academic Qualification in Health and Social Care (Extended Certificate) (RQF) comprises five mandatory units.

Mandatory units

Year	Unit Title	Unit number	GLH	Assessment Type
1	Unit 1 Principles and Practices of Working in Health and Social Care	L/651/5401	90	EA
	Unit 2 Health, Safety, and Infection Control in Health and Social Care	M/651/5402	90	NEA
2	Unit 3 Equality, Diversity, and Inclusion in Health and Social Care	R/651/5403	60	EA
	Unit 4 Safeguarding in Adult Health and Social Care	T/651/5404	60	NEA
	Unit 5 The Person-Centred Approach in Health and Social Care	Y/651/5405	60	NEA

Assessment approach

The assessment has been designed to ensure validity and its fitness for purpose, aligning with regulatory requirements for Alternative Academic Qualifications.

It is essential that all learners are assessed in English. This ruling also applies to all learner evidence presented for external quality assurance purposes.

Each unit in the AAQ is assessed separately using one of two different assessment methods:

- Examination Assessment (EA):
  - an externally set and marked examination
  - designed to assess the learner's understanding and application of knowledge under controlled conditions
- Non-examination Assessment (NEA):
  - an externally set brief that requires the learner to apply their knowledge and skills in a practical or research-based context
  - supports the demonstration of critical thinking and independent research skills through structured tasks
  - internally marked by a centre's assessors and externally moderated by TQUK.

For specific unit assessment requirements, centres should refer to the teaching content section in this Qualification Specification, from page 20.

Additionally, centres must refer to the Assessment Guidance for the Delivery of Alternative Academic Qualifications document. This essential document provides full instructions for the conduct of the EAs and NEAs and explains TQUK's approach to:

- the administration of both types of assessment under controlled conditions
- internally assessed marking
- standardisation and training
- external moderation.

Synoptic assessment

Whilst this qualification is unitised, there are opportunities for synoptic assessment through the NEA assessments of Units 4 and 5 in Year 2. Underpinning unit-specific content is the application of knowledge and research, project management, problem-solving, and critical thinking skills.

The approach to full compensatory marking and the use of a Uniform Mark Scheme (UMS) will also provide an indication of learners' holistic skills, knowledge, and understanding from across the qualification content.

Assessment Delivery

The following table shows the delivery approach for this qualification.

AAQ Extended Certificate Delivery Model										
Year 1										
Unit	**NEA Release**	**Standardisation activities**	**EA Window 1**	**EA Window 2**	**NEA completion, internal marking, retake opportunity**	**Initial external moderation**	**NEA results and feedback**	**NEA resubmission opportunity**	**Final external moderation**	**Results release**
1			Late January/ early February *	Mid-May						Window 1 April Window 2 July
2	September	Between 1 October and 28 February			Until 30 April	Between 1-14 May	Mid-May	Between 30 May and 14 June	Between 15-30 June	July
Year 2										
3			Late January/ early February *	Mid-May						Window 1 April Window 2 July
4	September	Between 1 October and 28 February			Until 30 April	Between 1-14 May	Mid-May	Between 30 May and 14 June	Between 15-30 June	
5	September	Between 1 October and 28 February			Until 30 April	Between 1-14 May	Mid-May	Between 30 May and 14 June	Between 15-30 June	

**** In the first year of delivery, there will be no January assessment window in 2027. Thereafter, two assessment window opportunities for the EA will be available annually.**

**** The results for the full qualification will be confirmed at the end of Year 2 in August to coincide with the release of A Level results.**

Guided Learning Hours (GLH)

These hours are made up of all contact time, guidance, or supervision of a learner by a lecturer, supervisor, tutor, trainer, or other appropriate provider of education or training.

The GLH for this qualification is 360 hours.

Directed Study Requirements

In addition to the guided learning hours, learners are expected to dedicate a certain amount of time to self-study and the completion of their Non-examination Assessment (NEA). This directed study time allows learners to review and consolidate their learning, engage in independent research, and prepare for the assessments.

This additional time spent on independent study and assessment preparation is an essential component of the learning process and contributes to the overall achievement of the qualification.

The directed study for this qualification is 40 hours.

Total Qualification Time (TQT)

The TQT provides an estimate of the overall time a learner will typically take to achieve and demonstrate the required level of attainment for the award of the qualification. The TQT includes both the guided learning hours and the directed study requirements.

For this qualification, the TQT is calculated by combining the guided learning hours and the estimated directed study hours. The TQT reflects the total commitment required from learners to successfully complete the qualification.

The TQT for this qualification is 400 hours.

Grading overview

The grading structure for the qualification comprises Pass, Merit, and Distinction for the component assessments and Pass, Merit, Distinction, and Distinction* for the overall qualification grade.

Please refer to the Grading and Marking section, on page 85, for full details.

Reasonable Adjustments and Special Considerations Policy

Learners who require reasonable adjustments or special considerations should discuss their requirements with their tutors. Centres must seek approval from TQUK before any adjustments or considerations can be put in place.

The centre should identify any potential difficulties a learner may face in accessing the Examination Assessment and Non-examination Assessment as early as possible and select appropriate adjustments to ensure accessibility. The centre staff are responsible for ensuring all reasonable adjustments are made and must follow TQUK's process for requesting and implementing adjustments. The centre must ensure that all approved reasonable adjustments are applied during the Examination Assessment and Non-examination Assessment.

For more information, please refer to TQUK's Reasonable Adjustments and Special Considerations Policy, or visit our website.

Course Delivery

Pre-course information

All learners should be given appropriate pre-course information regarding any TQUK qualifications. The information should explain the qualification, the fee, the form of the assessment, and any entry requirements or resources needed to undertake the qualification.

Initial assessment

Centres should ensure that any learner registered on a TQUK qualification undertakes some form of initial assessment. The initial assessment should be used to inform a teacher or tutor of the level of the learner's current knowledge, skills, and any additional specific support requirements the learner may need.

Initial assessment can be undertaken by a teacher/trainer in any form suitable for the qualification to be undertaken by the learner(s). It is the centre's responsibility to make available forms of initial assessment that are valid, applicable, and relevant to TQUK qualifications.

Resource Requirements

TQUK expects centres to provide access to appropriate resources and equipment to facilitate the successful delivery of this qualification.

Centres must ensure that facilities and equipment support a safe and engaging learning environment and align with the mandatory teaching content and outcomes. This must include access to digital resources and appropriate technical support.

We do not provide centres with a prescriptive list of equipment to have in place, nor do we stipulate the specific IT requirements or software packages centres should provide.

Learner Registration

Once approved to offer a qualification, centres must follow TQUK's procedures for registering learners. Learner registration is at the discretion of the centre and in line with equality legislation and health and safety requirements.

Centres must register learners before any assessment can take place.

Staffing Requirements

Centres delivering this AAQ must ensure they appoint individuals who are suitably qualified and competent to carry out their respective roles. It is the centre's responsibility to verify that all appointed personnel possess the necessary expertise and experience to deliver and assess the qualification.

The designated person

The centre must appoint a designated person in a senior leadership role to be responsible for overseeing the administration, delivery, and integrity of assessments.

The designated person could hold the following position:

- Head of Centre
- Principal
- Assistant Principal
- Vice Principal.

The designated person is responsible for ensuring that all staff involved in the teaching, assessment delivery, including administration, supervision, facilitation, management, and quality assurance of the AAQs comply with this document to maintain the security and integrity of the NEA and EA.

Any failure to comply may lead to a malpractice or maladministration investigation by TQUK.

The designated person may appoint additional non-teaching member(s) of staff to support the administration, delivery, and integrity of assessments.

The additional member(s) of staff could hold the following positions:

- Examinations Manager
- Examinations Officer
- Administrative Assistant.

Tutor/Teacher, Assessor, and Internal Quality Assurer requirements

All members of staff involved with the qualification (assessing or IQA) will need to be occupationally competent in the subject area being delivered. This could be evidenced by a combination of:

- a higher-level qualification in the same subject area as the qualification approval request
- experience in the delivery/assessment/IQA of the qualification requested
- work experience in the subject area of the qualification.

Staff members will also be expected to have a working knowledge of the requirements of the qualification and a thorough knowledge and understanding of the role of tutors/assessors and internal quality assurance. They are also expected to undertake continuous professional development (CPD) to ensure they remain up to date with work practices and developments associated with the qualifications they assess or quality assure.

Tutor or Teacher

Tutors or teachers who deliver a TQUK qualification must possess a teaching qualification appropriate for the level of qualification they deliver. This can include:

- Further and Adult Education Teacher's Certificate
- Cert Ed/PGCE/Bed/MEd
- PTLLS/CTLLS/DTLLS
- Level 3 Award/Level 4 Certificate/Level 5 Diploma in Education and Training.

Assessor

Staff who assess a TQUK qualification must possess an assessing qualification appropriate for the level of qualification they are delivering or be working towards a relevant qualification and have their assessment decisions countersigned by a qualified assessor. This can include:

- Level 3 Award in Assessing Competence in the Work Environment
- Level 3 Award in Assessing Vocationally Related Achievement
- Level 3 Award in Understanding the Principles and Practices of Assessment
- Level 3 Certificate in Assessing Vocational Achievement
- A1 or D32/D33.

Specific requirements for assessors may be indicated in the assessment strategy/principles identified in individual unit specifications.

Internal Quality Assurer

Centre staff who undertake the role of an Internal Quality Assurer (IQA) for TQUK qualifications must possess or be working towards a relevant qualification and have their quality assurance decisions countersigned by a qualified internal quality assurer. This could include:

- Level 4 Award in the Internal Quality Assurance of Assessment Processes and Practice
- Level 4 Certificate in Leading the Internal Quality Assurance of Assessment Processes and Practice
- V1 qualification (internal quality assurance of the assessment process)
- D34 qualification (internally verify NVQ assessments and processes).

It is best practice that those who quality assure qualifications also hold one of the assessing qualifications outlined above. IQAs must follow the principles set out in Learning and Development NOS 11 - Internally monitor and maintain the quality of assessment.

Useful Websites

- Office of Qualifications and Examinations Regulation
- Register of Regulated Qualifications

For further details regarding approval and funding eligibility, please refer to the following websites:

- Department for Education
- Learning Aim Reference Service (LARS)

You may also find the following websites useful:

- Skills for Care
- Health and Care Professions Council (HCPC)

- Care Quality Commission (CQC)
- Department of Health and Social Care (DHSC)

Mandatory Documentation

Centres must ensure they read this Qualification Specification alongside the following TQUK policies and guidance documentation:

- Appeals Policy
- Assessment Guidance for the Delivery of the Alternative Academic Qualifications
- Complaints Policy
- Conflict of Interest Policy
- Equality and Diversity Policy
- GDPR and Privacy Policy
- Reasonable Adjustments and Special Considerations Policy
- Malpractice and Maladministration Policy.

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Section 2: Teaching and Learning

Teaching Approach

Each unit includes the following information to support its delivery:

- an overview of the unit structure and its assessment approach
- an introduction to the unit and any key considerations that apply
- the mandatory teaching content.
- assessment requirements.

The mandatory teaching content has been structured to provide a clear distinction between the level of breadth and depth of knowledge that the learner must cover. It is presented in the specification as follows:

- **topic**: each subject area is introduced within a light blue box that provides a clear reference point for the content that will be covered
- **breadth:** the introductory "stem" sentence in each outcome outlines the overarching scope of the topic. It defines the key concepts, principles, approaches, and themes that learners are expected to understand. The use of amplification terminology further supports the exploration of the topic.
- **depth:** the bullet points following each stem sentence outline the specific details and expectations for learner knowledge and application. All bullet points must be covered, as they define the required level of detail and establish the scope and focus of mandatory teaching, learning, and assessment.

Each unit includes essential information to support effective planning and delivery. We outline the mode of assessment and any required resources, followed by the mandatory teaching content. Additionally, a dedicated assessment approach section specifies key details, including the assessment objectives (AOs) tested, important dates, and any specific requirements relevant to the topic.

Centres should inform learners that some topics within qualification specifications and their associated assessments may cover themes that certain learners may find triggering. Centres must be aware that assessment materials may include vocationally relevant content that could be sensitive.

Unit 1: Principles and Practices of Working in Health and Social Care

Unit Number:	L/651/5401		
Level:	3	**GLH:**	90
Unit Introduction:	Health and social care services rely on clear professional standards, regulations, and ethical principles to ensure high-quality, safe, and effective support for individuals. This unit explores the policies, legislation, and regulatory frameworks that shape practice, including the responsibilities of key organisations such as the Care Quality Commission (CQC) and the Health and Safety Executive (HSE). The unit examines the importance of policies and procedures in maintaining safety, promoting equality, and ensuring accountability in care settings. It also considers professional responsibilities, including safeguarding, confidentiality, and data protection. The role of multidisciplinary working and integrated care systems is explored, highlighting how different agencies collaborate to meet individuals' needs. By understanding the principles that govern health and social care, this unit provides a foundation for safe and effective practice. It supports the development of professional knowledge and ethical decision-making, which are essential for working in diverse health and social care environments.		
Assessment Type:	Examination Assessment (EA)		

Teaching content:	
1.1	**Legislation, policies, and procedures when working in health and social care**

1.1.1	The function of regulatory and inspection bodies within health and social care:
	
	• Office for Standards in Education, Children's Services and Skills (Ofsted):
	  ○ inspects and regulates services for children, young people, and learners
	  ○ ensures high standards in education, early years, and children's social care
	• Care Quality Commission (CQC):
	  ○ regulates and inspects health and social care services in England
	  ○ ensures safety, effectiveness, and quality of care
	• Health and Care Professions Council (HCPC):
	  ○ regulates healthcare professionals
	  ○ ensures professional standards and fitness to practise
	  ○ defines ongoing learning and competency expectations
	  ○ outlines ways professionals can maintain and develop their skills
	• Medicines and Healthcare Products Regulatory Agency (MHRA):
	  ○ regulates medicines, medical devices, and blood components for transfusion
	  ○ ensures safety, quality, and efficacy of medical products
	• General Medical Council (GMC):
	  ○ regulates doctors and maintains the medical register
	  ○ sets standards for medical education and practice
	• Nursing and Midwifery Council (NMC):
	  ○ regulates nurses, midwives, and nursing associates in the UK
	  ○ ensures professional competency and ethical practice
	• Social Work England (SWE):

Teaching content:	
	○ regulates social workers in England ○ ensures high standards of practice and professional conduct • Health and Safety Executive (HSE): ○ enforces workplace health and safety regulations ○ investigates serious workplace incidents and accidents • Office for Environmental Protection (OEP): ○ monitors and enforces compliance with environmental laws ○ investigates public bodies' adherence to environmental regulations • Local Authorities: ○ oversee public health, safeguarding, and social care services ○ commission and regulate local care provision • Integrated Care Boards (ICB): ○ plan and oversee healthcare services at a regional level ○ ensure collaboration between the NHS, social care, and voluntary sectors • Information Commissioner's Office (ICO): ○ enforces data protection laws ○ investigates breaches of personal data and privacy rights.
1.1.2	Purpose and application of legislation and professional standards in health and social care: • Legislation: ○ Health and Safety at Work Act 1974: ▪ protects workers and service users from risks and hazards ▪ requires risk assessments and workplace safety measures ▪ defines employer and employee responsibilities ○ The Equality Act 2010: ▪ gives legal protection for the 9 protected characteristics: • age • disability • gender reassignment • marriage or civil partnership • pregnancy and maternity • race • religion or belief • sex • sexual orientation ▪ protects individuals from discrimination ▪ requires reasonable adjustments in services and workplaces ▪ ensures fair treatment ○ Human Rights Act 1998: ▪ gives legal protection for 16 articles that protect dignity, autonomy, and fairness: • Article 2: Right to life • Article 3: Freedom from torture and inhuman or degrading treatment • Article 4: Freedom from slavery and forced labour • Article 5: Right to liberty and security • Article 6: Right to a fair trial • Article 7: No punishment without law • Article 8: Respect for your private and family life, home, and correspondence • Article 9: Freedom of thought, belief, and religion • Article 10: Freedom of expression • Article 11: Freedom of assembly and association • Article 12: Right to marry and start a family

Teaching content:	
	• Article 14: Protection from discrimination in respect of these rights and freedoms • Protocol 1, Article 1: Right to peaceful enjoyment of your property • Protocol 1, Article 2: Right to education • Protocol 1, Article 3: Right to participate in free elections • Protocol 13, Article 1: Abolition of the death penalty ▪ ensures individuals' rights are upheld in decision-making ▪ provides a legal basis to challenge poor care ○ Care Act 2014: ▪ establishes local authority responsibilities for assessing and meeting care needs for adults ▪ ensures person-centred approaches in care planning ▪ strengthens safeguarding for adults at risk of harm ○ Mental Capacity Act 2005: ▪ provides a legal framework for decision-making when capacity is impaired ▪ ensures decisions are made in an individual's best interests ▪ requires advocacy support where necessary ○ Health and Social Care Act 2012: ▪ established key reforms in the NHS ▪ places a duty on the Care Quality Commission (CQC) to ensure care providers meet essential standards ▪ promotes patient choice and involvement in decision-making ○ Health and Care Act 2022: ▪ supports integration of health and social care services ▪ enables data sharing for improved coordination of care ▪ specifies mandatory staff training ○ Data Protection Act 2018: ▪ protects personal data and privacy rights ▪ regulates how organisations collect, store, and use personal data ▪ ensures individuals have control over their information ○ Common Law Duty of Confidentiality: ▪ protects personal and medical information from unauthorised disclosure ▪ requires informed consent before sharing confidential data ▪ allows exceptions where disclosure is necessary for safeguarding or public interest • Professional standards: ○ CQC Fundamental Standards: ▪ defines minimum standards for safe and effective care ▪ used for regulatory inspections and compliance monitoring ○ National Occupational Standards: ▪ sets out competencies for different health and social care roles ▪ supports staff training and development ○ Skills for Care Code of Conduct: ▪ provides guidance on professional conduct, behaviour, and attitude in adult social care ▪ encourages best practice in person-centred care.
1.1.3	The purposes of using legislation to inform policies, procedures, and codes of conduct in health and social care: • establishes agreed ways of working • ensures all work aligns with current legislation and regulatory requirements • provides clear working practices that meet legal obligations • provides clear chain of accountability • demonstrates duty of care towards service users and staff • promotes safety and wellbeing through:

Teaching content:	
	○ safeguarding ○ confidentiality ○ whistleblowing ○ health and safety.
1.1.4	The consequences of not adhering to legislation, policies, and procedures when working in health and social care: • risk of harm to service users and staff: ○ increased risk of abuse, neglect, and exploitation ○ greater likelihood of physical or emotional harm • discrimination and inequality in care: ○ breaches of equality legislation leading to unfair treatment ○ exclusion or disadvantage for individuals based on protected characteristics • injury and disease outbreaks: ○ unsafe working environments leading to accidents ○ poor infection control measures increasing risk of disease • legal action and enforcement: ○ investigations by regulatory bodies ○ fines, sanctions, or closure of services ○ loss of professional registration for individuals • impact on public trust and reputation: ○ loss of confidence in care providers and services ○ damage to organisational credibility and funding opportunities.
1.2	**Health and social care provision**
1.2.1	A range of healthcare and social care provision: • healthcare provision: ○ acute services (ACS): ▪ hospitals ▪ treatment centres ▪ clinics ○ urgent care services: ▪ minor injury units ▪ urgent care treatment centres ▪ walk-in centres ○ hospice services (HPS) ○ mental health hospital services ○ prison healthcare services (PHS): ▪ drug rehabilitation programmes ○ community healthcare services (CHC): ▪ district nursing ▪ community physiotherapy team ▪ support worker team ○ doctor consultation services: ▪ general practitioner (GP) practices ▪ vaccination services ▪ early medical abortion clinics ○ dental services • social care provision: ○ care homes with nursing (CHN): ▪ nursing home ▪ convalescent home ▪ respite care

Teaching content:	
	▪ hospice care ○ care home service without nursing (CHS): ▪ residential home ▪ rest home ▪ respite care ○ domiciliary care services (DCC) ○ extra care housing services (EXC) ▪ purpose-built accommodation ○ Shared Lives schemes.
1.2.2	The purpose of integrating health and social care services: • concept of service integration: ○ collaboration between healthcare and social care services to provide holistic, person-centred support ○ coordinated approaches to meet the physical, emotional, and social needs of individuals • way in which services integrate: ○ joint working between professionals ▪ health and social care staff working together to improve care planning ▪ information sharing between medical teams, care providers, and local authorities ▪ coordinated assessments and referrals ○ integration in care settings: ▪ nursing homes liaising with healthcare professionals for medical support ▪ GPs working in partnership with domiciliary care providers to monitor patients at home ▪ hospitals working with social services teams to arrange post-discharge care ○ multi-agency working and shared responsibility: ▪ NHS, social care, and voluntary sector organisations collaborating ▪ joint funding arrangements and shared decision-making ▪ ensuring continuity of care across different settings.
1.2.3	Factors that can influence health and social care service provision: • demand: ○ population needs and demographic changes ○ increase in long-term conditions and complex care needs • location: ○ urban versus rural access to services ○ availability of transport and infrastructure • staffing: ○ workforce shortages and recruitment challenges ○ specialist skills and training requirements • availability: ○ opening hours and waiting times ○ capacity of services to meet patient needs • partnership working: ○ collaboration between health, social care, and voluntary sectors ○ multi-agency working to improve care coordination • policies/procedures: ○ legislative frameworks impacting service delivery ○ internal organisational policies affecting service provision • costs/funding: ○ impact of government funding and budget allocations ○ service fees, personal budgets, and financial accessibility

Teaching content:	

	• management:
	  ○ leadership and decision-making in service provision
	  ○ organisational structure and resource allocation.

1.3	**Roles and responsibilities when working in health and social care**

1.3.1	Roles and responsibilities within health and social care:
	
	• roles in healthcare:
	  ○ GP
	  ○ nurse
	  ○ surgeon
	  ○ dentist
	  ○ dietician
	  ○ speech and language therapist
	  ○ physiotherapist
	  ○ psychiatrist
	  ○ mental health psychologist
	  ○ occupational therapist
	  ○ personal assistant
	  ○ counsellor
	  ○ optician
	  ○ pharmacist
	• responsibilities in healthcare:
	  ○ responding to patient symptoms:
	  ▪ assessment
	  ▪ diagnosis
	  ▪ testing
	  ▪ treatment
	  ▪ safeguarding
	  ○ medical imaging and radiology:
	  ▪ X-rays
	  ▪ CT scans
	  ▪ MRIs
	  ▪ ultrasounds
	  ○ surgery
	  ○ nursing care:
	  ▪ dressing wounds
	  ▪ administering medication
	  ▪ monitoring
	  ○ pharmaceutical services:
	  ▪ dispensing medication
	  ▪ providing guidance to patients
	  ▪ immunisation
	  ○ rehabilitation:
	  ▪ counselling
	  ▪ therapies
	  ▪ exercises
	  ▪ supportive devices
	• roles in social care:
	  ○ social worker
	  ○ care worker
	  ○ advocate
	  ○ support worker
	  ○ housing officer
	  ○ probation officer
	  ○ teaching assistant (special educational needs and disabilities (SEND))

Teaching content:	
	○ independent reviewing officer • responsibilities in social care: ○ assessing needs: ▪ physical ▪ emotional ▪ social ○ develop care plans ○ provide personal care and support daily activities ○ administer medication ○ monitor health and wellbeing ○ provide emotional support ○ facilitate social interaction ○ advocacy: ▪ assist individual to navigate systems and support services ○ safeguarding and crisis intervention.
1.3.2	The role of the 6Cs in delivering high-quality health and social care: • definition and purpose of the 6Cs: ○ care – delivering person-centred care ○ compassion – showing kindness and empathy ○ competence – maintaining professional knowledge and skills ○ communication – ensuring clear, effective exchanges with service users and colleagues ○ courage – advocating for service users and challenging poor practice ○ commitment – being dedicated to continuous improvement • application of the 6Cs in professional practice: ○ contribute to safe and high-quality care ○ contribute to building relationships with service users, families, and colleagues • consequences of not applying the 6Cs: ○ breakdown in trust and communication ○ reduced quality of care and negative patient experiences ○ potential safeguarding risks.
1.3.3	The role of core skills and behaviours when working in health and social care: • National Dignity Standards: ○ have a zero-tolerance approach to all forms of abuse ○ support people with the same respect you would want for yourself or a family member ○ treat each person as an individual by offering a personalised service ○ enable people to maintain the maximum possible level of independence, choice, and control ○ listen and support people to express their needs and wants ○ respect people's right to privacy ○ ensure people feel able to complain without fear of retribution ○ engage with family members and carers as care partners ○ assist people to maintain confidence and a positive self-esteem ○ act to alleviate people's loneliness and isolation • effects of failing to uphold dignity on service users and staff relationships: ○ emotional distress and low self-esteem due to feeling ignored, disrespected, or devalued ○ increased vulnerability to abuse and neglect ○ loss of trust in care providers ○ resistance to care or disengagement ○ higher risk of depression, anxiety, and other mental health issues

Teaching content:	
	○ physical harm ○ legal and reputational consequences for organisations failing to meet dignity standards ○ negative workplace culture where staff lack accountability in upholding dignity • the impact of dignity and respect on service users and staff relationships: ○ promotes trust and positive relationships between staff and individuals receiving care ○ enhances emotional and psychological wellbeing ○ supports person-centred care ○ encourages independence by giving individuals control over their own decisions and choices ○ reduces distress, anxiety, and fear in vulnerable individuals ○ improves compliance with treatment and care plans as individuals feel respected and involved • the influence of verbal and non-verbal communication: ○ active listening and questioning to improve patient understanding ○ the role of tone of voice in de-escalating challenging situations • problem-solving and decision-making: ○ effectiveness of different approaches to managing risk ○ the role of a professional's judgement in responding to ethical dilemmas • building trust and professional relationships: ○ empathy and patience support individuals ○ trust and consistency encourage confidence and independence in service users ○ long-term impact of strong professional relationships on wellbeing and care outcomes • the significance of monitoring and reporting: ○ spotting patterns and changes in behaviour or health to prevent deterioration ○ the impact of poor recording and information sharing on service users and organisation • collaboration and teamwork to improve quality of care: ○ the role of teamwork to improve care outcomes ○ importance of following direction while maintaining professional independence.
1.3.4	The influence of own values, beliefs, and experiences on the delivery of care: • values - the standards and principles that guide attitudes, behaviours, and judgements and influence the way in which an individual lives their life: ○ acquired throughout an individual's life and shaped by experiences and learning ○ can change over time ○ influenced by education, background, culture, own networks, and beliefs ○ seen as a moral compass: ▪ honesty ▪ respect ▪ compassion • beliefs - trust or conviction placed in something being true or valid: ○ influences values and morals ○ shapes ethical decision-making • experiences - practical knowledge gained from direct or indirect encounters: ○ can shape beliefs and values positively or negatively ○ bias and world view are influenced by personal experiences ○ direct: ▪ personal interaction ○ indirect: ▪ book

Teaching content:	
	▪ media ▪ social • influence on delivery of care: o potential conflict between personal and professional values o impact of cultural, ethnic, religious, and personal beliefs and experience on care delivery o challenges between maintaining objectivity and professionalism o strategies to manage personal influences in professional settings.
1.3.5	The importance of working within the limits of own role and competence: • legal implications if individual does not adhere to role boundaries • risk of causing harm to other individuals or self • non-adherence to fundamental standards or occupational standards may lead to safeguarding issues • potential disciplinary concern • quality of service provided to service user negatively impacted • awareness of own level of experience/competency • scope of practice • supports positive workplace culture • accountability for reporting any concerns or inactions within setting • training required to undertake certain functions • recognise and maintain professional boundaries when supporting an individual.
1.3.6	Sources that can be utilised when reporting concerns above own role and responsibility: • policies for reporting concerns: o whistleblowing for reporting unsafe, illegal, or unethical practices o safeguarding for raising concerns about abuse, neglect, or harm o confidentiality for ensuring information is shared appropriately when reporting concerns o health and safety for identifying and escalating workplace hazards and risks o duty of candour for promoting transparency and honesty when incidents occur • individuals involved in reporting concerns: o management/supervisor as the first point of contact for concerns within an organisation o advocate for supporting individuals in raising concerns when they struggle to do so independently o social worker for investigating safeguarding issues and care-related complaints o union representative for providing support to staff in escalating workplace-related concerns • organisations or groups that respond to concerns: o Care Quality Commission (CQC) regulates care services and investigates reported failures o Safeguarding Adults Board (SAB) oversees safeguarding responses at a local level o Police will investigate criminal offences related to abuse, neglect, or safety risks o Health and Safety Executive enforces health and safety regulations in care settings.
1.4	**Communication in health and social care**
1.4.1	The importance of clear and open communication within health and social care

Teaching content:	
	• promotes and coordinates effective and safe care of the individual • promotes understanding of treatment, care, medication, and their outcomes • ensures the individual's needs, wishes, and preferences are met, enhancing person-centred care • supports individuals to make informed choices about their care • strengthens partnership working and multi-disciplinary collaboration • reduces negative emotions such as fear, anger, or anxiety • increases self-esteem and confidence • advocates equality, diversity, and inclusion • promotes the 6Cs and core values, ensuring high-quality care standards • ensures staff awareness of different communication needs.
1.4.2	The potential barriers to communication in health and social care: • language barriers • past trauma or distress • dementia and cognitive decline • mental health conditions • sensory impairment • cultural differences • substance abuse • ineffective communication from professionals • learning disabilities.

1.4.3	Communication methods to meet individual needs in health and social care:
	
	• verbal communication:
	  ○ direct interaction
	  ○ instructions
	  ○ discussions
	• non-verbal communication:
	  ○ body language
	  ○ facial expressions to convey emotion and reaction
	  ○ gestures
	• written communication:
	  ○ accurate record keeping
	  ○ information sharing
	• visual communication:
	  ○ use of images or symbols to aid understanding
	• inclusive communication methods:
	  ○ Braille
	  ○ picture exchange communication system (PECS)
	  ○ augmentative and alternative communication (AAC)
	  ○ British Sign Language (BSL)
	  ○ Makaton
	• human support:
	  ○ interpreter
	  ○ translator
	  ○ advocate
	  ○ speech therapist
	  ○ family/friends known to the individual
	• technical aids:
	  ○ hearing aids
	  ○ mobile phone
	  ○ voice box.

Teaching content:	
1.4.4	Strategies to overcome barriers to communication in health and social care • provide staff training on accessible communication methods • use preferred communication methods based on individual needs • adapt communication techniques and ensure cultural sensitivity • use clear, jargon-free language to enhance understanding • ensure an appropriate environment for communication • provide enough time for individuals to process and respond • use active listening skills and appropriate non-verbal cues • offer alternative ways of expressing choices, such as through advocacy or assistive technology.
1.5	**Understand partnership working in health and social care**
1.5.1	The advantages and disadvantages of partnership working in health and social care: • advantages of working in partnership: o ensures seamless transitions between services o reduces gaps and delays in care provision o supports better decision-making with access to a wider range of expertise o reduces duplication and conflicting advice o reduces costs by streamlining services and preventing duplication o allows for joint funding and shared staffing o encourages collaboration between medical, social, and psychological professionals o improves care quality by addressing all aspects of a service user's needs o enables early identification of risks and faster intervention o ensures compliance with legal and ethical standards • disadvantages of working in partnership: o differences in priorities, processes, and record-keeping across services o risk of miscommunication or conflicting advice o some organisations may dominate decision-making o differing professional perspectives can lead to disagreement o multi-agency involvement can slow response times o bureaucratic barriers may impact urgent care provision o sharing sensitive information requires clear legal and ethical boundaries o risk of non-compliance with data protection laws o limited budgets may prevent full integration of services o differences in funding models across sectors can create challenges.
1.5.2	Strategies to improve communication when working in partnership with others: • maintaining regular contact and meetings to ensure shared understanding • confirming preferred communication method to accommodate accessibility needs and professional preferences • effective use of communication systems (for example, handover documentation, emails, digital records) • sharing information appropriately while adhering to confidentiality policies • effective record keeping, ensuring accuracy and accountability • supporting individual with communication using most appropriate methods (for example, assistive technology, translation services, or adapted formats).
1.5.3	Approaches to resolving conflict when working in partnership with others: • clarify the areas of conflict and acknowledge any differences of opinion • identify root cause of the disagreement

Teaching content:	
	• encourage open communication and discussion • focus on finding solutions rather than placing blame • active listening and ensure all parties have an opportunity to express concerns • ensure the individual is at the centre of all decision-making • establish clear expectations for information sharing • encourage transparency to mitigate future misunderstandings • work towards rebuilding trust, mutual support, and respect • promote shared goals for continuous improvement • escalate to manager, senior manager, or regulatory body to agree strategies to mediate and seek resolution • follow escalation procedures to maintain professional integrity.
1.6	**Principles and practices relating to confidentiality in health and social care**
1.6.1	The principles of 'confidentiality' in the context of health and social care: • essential aspect of providing care • sensitive information is treated confidentially and with respect • duty of care when confidential information must be shared when required for the effective care of an individual • disclosing information about an individual on a need-to-know basis • all information for the benefit of the public/in the public domain should be kept anonymous • right to object to sharing information should be respected • policies and processes should be in place to ensure rules are followed relating to confidentiality • individual should be informed of information held and who has access to it.
1.6.2	Strategies to maintain confidentiality during day-to-day communication in health and social care: • hold conversations in a private space to prevent unauthorised access to information • securely store physical and digital confidential data • restrict access to confidential information • anonymise information where possible to protect identities • follow policies and procedures that govern confidentiality and data protection • share only necessary information on a need-to-know basis • ensure computer screens are out of view of people in the vicinity • use up-to-date IT systems, ensuring log-in details and passwords are changed on a regular basis • report any data breaches immediately.

1.6.3	Potential conflict between maintaining an individual's confidentiality while needing to disclose information:
	
	• duty of care:
	  ○ balancing confidentiality with the responsibility to protect individuals from harm
	  ○ assessing when breaching confidentiality is justified
	• safeguarding concerns:
	  ○ risk of harm to the individual or others if information is not disclosed
	  ○ legal and ethical considerations when overriding confidentiality
	• relationship with individual:
	  ○ impact on trust and professional relationships
	  ○ potential reluctance of individuals to share important information in the future

Teaching content:	

	• legal obligation/public interest:
	  ○ situations where disclosure is legally required (for example, serious crime, public health risks)
	  ○ evaluating whether disclosing information is in the best interest of wider society
	• referral to an essential service:
	  ○ ensuring the individual receives the necessary support (for example, medical, mental health, or social services)
	  ○ navigating confidentiality policies while ensuring access to care.

1.6.4	Sources of support for maintaining and escalating confidentiality in health and social care:
	
	• working within own role:
	  ○ organisation policies and procedures
	  ○ guidance from a manager
	  ○ consult a Caldicott guardian
	• escalating confidentiality concerns to external sources:
	  ○ Care Quality Commission
	  ○ advocate
	  ○ NHS and Social Care Record Guarantees for England
	  ○ NHS Digital (Health and Social Care Information Centre) Guidance
	  ○ NHS England Data Security and Protection Toolkit
	  ○ Information Commissioner's Office (ICO)
	  ○ social worker.

1.7	**Effective information handling in health and social care**
1.7.1	The importance of maintaining records that are up to date, complete, accurate, and legible: • support professionals in making informed decisions • documents sensitive information about an individual's care • tracks stages of an individual's care • identifies roles and responsibilities • acts as a record of accidents and incidents • mitigates risks • enhances quality of treatment • ensures compliance with procedural and legal responsibilities • may be required for legal reasons • supports capacity assessment and individual decision amendment • identifies patterns in behaviour or incidents • follow plain English guidelines to avoid misunderstanding or misinterpretation.
1.7.2	The consequences of failing to handle information effectively in health and social care: • breach in confidentiality • regulatory action, fines, or legal proceedings • employment termination • reputational damage • breakdown in relationship with service users and staff • increased risk of harm to physical or mental health • increased risk of abuse or exploitation • prevention of person-centred care • inconsistent care and unsafe practice.

Teaching content:	
1.8	**Professional development**

1.8.1	The importance and impact of continuing professional development (CPD) in health and social care:
	
	• importance of CPD in maintaining high-quality care:
	  ○ maintain a sufficiently skilled and knowledgeable workforce
	  ○ promote safe and effective practice
	  ○ ensures the safe care and treatment of individuals
	  ○ can be a legal requirement depending on the profession and regulatory body
	  ○ keeps staff up to date with changes in practice or legislation
	  ○ develops multi-skilled staff
	  ○ supports staff career progression
	  ○ improves staff retention
	• the impact of CPD on individuals receiving care:
	  ○ enhances service quality and promotes person-centred care
	  ○ reduces risks of errors or outdated practices
	  ○ supports better communication and care coordination
	• the impact of CPD on staff:
	  ○ increases confidence and competence in delivering high-quality care
	  ○ encourages personal growth and job satisfaction
	  ○ prevents professional stagnation and loss of motivation
	• the impact of CPD on the organisation:
	  ○ ensures compliance with legal and regulatory requirements
	  ○ meet key performance indicators as part of any service level agreement (SLA)
	  ○ strengthens reputation and quality ratings
	  ○ reduces turnover by fostering a culture of learning and career growth.

1.8.2	The influence of standards and frameworks of CPD within health and social care:
	
	• standards and frameworks:
	  ○ Knowledge and Skills Framework (KSF) within the NHS
	  ○ Care Quality Commission (CQC) Fundamental Standards for Quality and Safety
	  ○ CPD standards within the Health and Care Professions Council (HCPC)
	  ○ Code of Conduct (Skills for Health)
	  ○ Minimum standards
	  ○ National Occupational Standards (NOS)
	  ○ Professional regulatory bodies - examples include, Social Work England, Health and Care Professional Council (HCPC), Nurse & Midwifery Council (NMC), General Medical Council (GMC) professional competency standards
	• influence on professional development:
	  ○ provides a structured approach to CPD, ensuring consistency in professional development
	  ○ ensures regulatory compliance, preventing breaches of professional standards
	  ○ promotes staff development by outlining clear learning expectations and competencies
	  ○ supports career progression by mapping training pathways to advanced roles
	  ○ maintains quality and safety by ensuring staff knowledge aligns with best practices
	  ○ encourages lifelong learning by requiring ongoing skills updates and knowledge development.

1.8.3	Strategies to overcome barriers to professional development in health and social care: • limited time or workload pressures reduce availability for training: ○ short, focused learning sessions during shifts

Teaching content:	
	○ protected study time to ensure staff can engage in CPD without work disruptions ○ CPD as part of performance reviews to encourage engagement • financial barriers: ○ allocated training budget to subsidise CPD costs ○ grants, bursaries, or external funding options ○ peer-led training to reduce costs while sharing expertise internally ○ free or low-cost online training resources ○ collaborate with external training providers • limited ability to release staff for training: ○ staff cover plans ○ e-learning modules or blended learning ○ offer CPD during quieter periods • shift work and scheduling challenges prevent staff from attending CPD sessions: ○ flexible learning options ○ weekend, evening, or split-shift training sessions ○ utilise a rota system to fairly distribute CPD opportunities • limited encouragement or investment in staff development: ○ CPD incentives, such as career progression links or recognition schemes ○ incorporate CPD into supervisions, appraisals, and goal setting ○ promote a culture of learning • unstructured CPD pathways create uncertainty about career progression: ○ develop clear CPD pathways, outlining learning expectations and career progression routes ○ mentoring and coaching ○ align CPD with qualification frameworks and industry-recognised credentials • staff confidence, motivation, or work-life balance challenges: ○ encourage self-directed learning to allow staff to develop at their own pace ○ peer support groups or CPD mentors ○ CPD that aligns with individual interests and career goals • access to e-learning and digital training resources: ○ equal access to digital devices and internet connectivity ○ provide basic IT skills training ○ offer printed or alternative resources.
1.8.4	Application of methods to analyse skills gaps and plan professional development in health and social care: • methods for identifying skills gaps: ○ self-assessment of strengths and weaknesses ○ peers/manager feedback ○ reflective practice ○ formal appraisals/supervisions • planning professional development: ○ agree development areas based on skills gaps ○ set SMART goals: ▪ Specific ▪ Measurable ▪ Achievable ▪ Realistic ▪ Time-bound ○ consider mandatory CPD requirements ○ select suitable learning approaches: ▪ formal training ▪ mentoring ▪ self-directed study

Teaching content:	
	▪ external training providers ▪ professional networks.
1.8.5	The benefits and limitations of personal development plans in health and social care: • benefits of personal development plans: o provides structured framework for own development o identifies and tracks progress o encourages continuous learning o supports high-quality care o examines the wider impact on the member of staff o examines the wider holistic impact on the individuals supported by the setting or service • limitations of personal development plans: o requires regular review to maintain currency o relies on self-motivation, engagement, and commitment o unrealistic or overambitious goals/objectives can impact motivation.
1.8.6	The importance of evaluating the impact of learning opportunities in health and social care: • influence on policies and procedures: o updates to existing protocols to reflect best practices o ensures compliance with regulatory and organisational standards • implementation of new equipment: o requires staff training to ensure safe and effective use o can improve efficiency and quality of care • dissemination of information across the setting: o supports knowledge sharing to improve staff awareness o ensures learning is embedded into daily practice • changes to risk assessments: o enhances workplace safety and minimises potential hazards o supports proactive identification and management of risks • effect on staff morale and retention: o encourages professional growth and job satisfaction o potential for increased engagement when development opportunities are available • improvements in communication: o supports multi-disciplinary working and collaborative decision-making o reduces misunderstandings and enhances teamwork • reduction in behavioural incidents: o strengthens conflict resolution and de-escalation techniques o promotes a safer and more inclusive environment for service users and staff.
1.9	**The use of reflective practice in health and social care**
1.9.1	The influence of reflective practice in health and social care: • purpose of reflective practice: o develops professional awareness by identifying strengths and areas for improvement o supports critical thinking and self-examination o identifies biases and assumptions in care decisions o encourages continuous learning and professional growth o improves decision-making by analysing past actions • influence of reflective practice:

Teaching content:	
	○ maintains high-quality care but requires time and structure ○ builds confidence and accountability, but may be challenging for some ○ encourages proactive learning but depends on applying insights effectively.
1.9.2	The influence of reflective models on professional development: • Gibbs' reflective cycle: ○ structured approach with six stages: ▪ description ▪ feelings ▪ evaluation ▪ analysis ▪ conclusion ▪ action plan ○ advantages: ▪ step-by-step structure ensures a clear and logical reflection process ▪ accessible to all professionals regardless of experience level, making it a widely used model ▪ encourages deep reflection, particularly in emotional or high-stakes situations ▪ focuses on future improvement, helping individuals refine their practice over time ▪ works well in structured learning environments, such as education or supervision ○ disadvantages: ▪ can become repetitive if used too rigidly, leading to formulaic responses rather than meaningful reflection ▪ lack of flexibility – may not be suitable for informal or real-time reflection ▪ can feel overly structured for professionals who prefer a more fluid or creative approach to reflection ▪ may not always promote immediate action, as it involves a cycle rather than spontaneous adaptation • Driscoll's model of reflection: ○ based on three questions: ▪ "what?" (happened) ▪ "so what?" (does this mean) ▪ "now what?" (will I do) ○ advantages: ▪ straightforward and time-efficient, making it ideal for fast-paced environments ▪ easy to remember and apply, allowing integration into daily practice with minimal effort ▪ encourages immediate reflection and action ▪ useful for those new to reflection as it provides a simple yet effective framework ○ disadvantages: ▪ lacks depth compared to more structured models, potentially leading to surface-level reflections ▪ limited focus on emotional aspects that could be crucial in person-centred care ▪ less guidance on learning from experience ▪ may not support long-term professional development as it does not encourage ongoing review • Kolb's Learning Cycle: ○ focuses on experiential learning: ▪ concrete experience

Teaching content:	
	▪ reflective observation ▪ abstract conceptualisation ▪ active experimentation ○ advantages: ▪ highly practical and helps professionals improve their skills through active learning ▪ encourages adaptability as individuals modify their actions based on past experiences ▪ effective for hands-on learning ▪ aligns well with professional development frameworks ○ disadvantages: ▪ requires high levels of engagement, meaning those less proactive in reflection may struggle to benefit ▪ not ideal for situations requiring immediate reflection ▪ can be difficult to apply without structured support ▪ theory-heavy approach may not suit professionals who prefer a more intuitive or narrative style of reflection.
1.9.3	Benefits and challenges of reflective practice in health and social care: • benefits: ○ develops professional awareness by identifying strengths and areas for improvement ○ supports critical thinking and self-examination ○ identifies biases and assumptions in care decisions ○ encourages continuous learning and professional growth ○ improves decision-making by analysing past actions ○ supports professional development of the practitioner ○ improves outcomes for: ▪ team members ▪ colleagues and other professionals ▪ service users ○ enhances quality of service by encouraging learning from experience ○ promotes equality, diversity, and inclusion through self-reflection • challenges: ○ requires time and structure, which can be difficult in fast-paced environments ○ depends on honesty and self-awareness, which some may struggle with ○ can feel repetitive if using the same model frequently ○ risk of negative self-reflection, where practitioners focus too much on failures rather than learning ○ effectiveness depends on applying insights, but not all professionals act on reflections.

Unit 1: Assessment Approach

The mode of assessment used for this unit is an Examination Assessment (EA). This assessment method is externally set and marked by TQUK, ensuring consistency and reliability in the evaluation of a learner's knowledge and understanding.

An overview of the assessment approach is outlined in the table below:

Assessment description	The EA comprises a balance of multiple-choice questions (MCQs), extended-response questions (ERQs), and short-answer questions (SAQs).
Assessment windows	Late January/early February** and early May Centres have the flexibility to timetable the Examination Assessment within the specified assessment window.
Duration of EA	2 hours

** **Important**: in the first year of delivery, there is no assessment window opportunity in January 2027. Thereafter, EAs will be available annually in late January/early February and mid-May.

The Examination Assessment will be conducted under exam conditions in a controlled environment. Centres must refer to the Assessment Guidance for the Delivery of Alternative Academic Qualifications document available on our website for further information to support the administration of the EA.

The assessment has been carefully aligned with the unit's assessment objectives (AOs) to create a consistent framework for learners. The table below confirms the assessment objectives that will be covered in the Examination Assessment.

Assessment objective	Description
AO1 – Recall knowledge and information	Learners are to **recall** knowledge and information
AO2 – Apply knowledge and information	Learners are to **apply** knowledge and information to situations and contexts relevant to the given sector
AO3 – Interpret, analyse or evaluate information, ideas or different viewpoints	Learners are able to **interpret**, **analyse,** or **evaluate** information, ideas, or different viewpoints to make **judgements** that are reasoned or draw conclusions.

Unit 2: Health, Safety, and Infection Control in Health and Social Care

Unit Number:	M/651/5402		
Level:	3	**GLH:**	90
Unit Introduction:	Ensuring the health and safety of individuals, staff, and visitors is a fundamental responsibility in all health and social care settings. This unit explores the legal and professional frameworks that govern workplace safety, risk management, and infection prevention. It examines key legislation such as the Health and Safety at Work Act 1974and the Control of Substances Hazardous to Health (COSHH) Regulations 2004. The unit also considers the role of risk assessments in identifying and minimising hazards, as well as the procedures for responding to accidents, emergencies, and fire safety risks. Infection control measures, including hygiene protocols and the use of personal protective equipment (PPE), are explored to highlight their role in preventing the spread of disease. By developing an understanding of workplace health and safety, this unit supports best practice in risk management and infection prevention, ensuring that individuals receive care in a safe and well-regulated environment.		
Assessment Type:	Non-examination Assessment (NEA)		

Teaching content:	
2.1	**Health and Safety legislation, policies, and procedures**
2.1.1	The function of legislation, policies, and procedures in health and social care: • legislation: ○ Health and Safety at Work etc Act 1974 (HASAWA) (Amendments 2015): ▪ defines employer and employee responsibilities for maintaining a safe working environment ▪ requires appropriate training, risk assessments, and preventative measures to minimise harm ○ Management of Health and Safety at Work Regulations 1999 (Amendments 2006): ▪ establishes the duty to conduct risk assessments and implement control measures ▪ ensures that employers provide safe systems of work and training ○ Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations (2013) (RIDDOR) – in relation to injuries and dangerous occurrences: ▪ requires reporting of workplace accidents, injuries, and hazardous incidents ▪ ensures accountability and investigation of serious health and safety breaches ○ Food Safety and Hygiene (England) Regulations 2013: ▪ ensures safe food storage, preparation, and hygiene in care settings ▪ reduces the risk of food-borne illnesses ○ Health and Safety (First Aid) Regulations 1981 (Amendment 2013): ▪ requires employers to provide adequate first aid training, equipment, and facilities ▪ ensures timely medical assistance is available for staff and service users ○ Manual Handling Operations Regulations 1992 (as amended 2016) (MHOR): ▪ governs safe moving and handling of individuals and objects

Teaching content:	
	▪ reduces the risk of musculoskeletal injuries through correct techniques and equipment use ○ Control of Substances Hazardous to Health Regulations 2004 (COSHH): ▪ regulates the use, storage, and disposal of hazardous substances ▪ protects individuals from exposure to harmful chemicals, biological agents, and medication-related risks ○ Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 ○ Fire Safety (England) Regulations 2022: ▪ sets out fire prevention measures and emergency procedures ▪ ensures fire safety assessments and staff training are in place ○ Environment Act 2021 (Commencement No3) Regulations 2022: ▪ sets out legal obligations for reducing environmental hazards in care settings ▪ ensures waste management and pollution control align with sustainability goals ○ Controlled Waste (England and Wales) Regulations 2012: ▪ classifies different types of controlled waste, including healthcare and clinical waste ▪ ensures proper handling, disposal, and record-keeping of hazardous materials ○ Hazardous Waste Regulations 2005: ▪ governs the identification, storage, and disposal of hazardous waste in care settings ▪ protects individuals from exposure to harmful substances ○ Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: ▪ regulates the safe use and disposal of sharp instruments such as needles and scalpels ▪ reduces the risk of needlestick injuries and blood-borne infections ○ Public Health (Control of Disease) Act 1984: ▪ provides legal authority to manage public health risks, such as infectious disease outbreaks ▪ allows enforcement of quarantine and infection control measures ○ Personal Protective Equipment at Work Regulations 1992 (Amendment 2022): ▪ requires employers to provide appropriate PPE to staff where risks cannot be avoided ▪ ensures PPE is fit for purpose, well-maintained, and correctly used • standards, policies, and procedures that guide practice: ○ Health and Safety Executive (HSE) Management Standards – sets expectations for reducing work-related stress, improving health and wellbeing, and maintaining a safe work environment ○ emergency procedures – outlines responses to fire, medical emergencies, equipment failures, and security threats ○ risk assessments – ensure hazards are identified and appropriate controls are put in place to reduce risks ○ moving and handling procedures – provides guidance on safe lifting techniques and use of specialist equipment to prevent injuries ○ food hygiene procedures – establishes safe food storage, preparation, and hygiene practices to reduce the risk of food-borne illnesses ○ use of chemicals policy – ensures COSHH regulations are followed when handling and storing hazardous substances ○ waste disposal policy – defines procedures for disposing of general, clinical, and hazardous waste safely ○ medication policy – outlines safe administration, storage, and disposal of medication to minimise errors and harm ○ infection control policy – sets hygiene protocols to prevent the spread of infection, including hand hygiene and isolation procedures

Teaching content:	
	○ PPE policy – details the correct selection, use, and disposal of personal protective equipment to minimise exposure to risks • application of legislation, policies, and procedures in practice: ○ ensure legal compliance by translating laws into day-to-day working practices ○ conduct risk assessments, training, and control measures to prevent workplace incidents ○ use PPE, hand hygiene protocols, and COSHH regulations to minimise disease transmission ○ establish clear employer and employee responsibilities under HASAWA and RIDDOR ○ implement policies for handling accidents, fires, and infectious outbreaks ○ ensure safe medication handling, waste disposal, and moving/handling techniques.
2.2	**The purpose of risk assessments in health and social care settings**
2.2.1	The purposes of risk assessments in promoting health and safety in health and social care settings: • identify potential hazards and risks • assess level of risk • promote culture of safety in setting • protect individuals and staff from potential harm • develop control measures • ensure compliance with legal and organisational requirements • promote individual choice and autonomy.
2.2.2	Application of risk assessment planning in health and social care: • identify hazards: ○ consider physical, biological, chemical, and environmental hazards ○ observe workplace conditions and daily activities ○ consult staff and service users for potential risks • assess the level of risk: ○ evaluate who might be harmed and how ○ assess the likelihood and severity of potential harm ○ prioritise risks that require immediate action • decide on and implement control measures: ○ apply the hierarchy of control: ▪ eliminate risk where possible ▪ substitute unsafe processes ▪ implement engineering and administrative controls ▪ provide personal protective equipment as a last resort ○ ensure compliance with health and safety policies and legislation • record findings and create an action plan: ○ complete risk assessment templates with identified hazards and control measures ○ assign responsibilities for implementing safety measures ○ set a review date to monitor effectiveness • monitor and review risk assessment effectiveness: ○ regularly update risk assessments based on new hazards, incidents, or care needs ○ evaluate whether control measures are working ○ provide staff training if required.
2.2.3	Factors to consider when reviewing and updating risk assessments in health and social care:

Teaching content:	

	• environmental and workplace changes:
	  ○ introduction of new equipment, facilities, or layout modifications
	  ○ identification of previously overlooked hazards during inspections
	• emerging risks and changing threats:
	  ○ new viruses, infections, or workplace hazards
	  ○ increase in reported incidents, accidents, or near misses
	• changes in an individual's needs:
	  ○ adjustments due to medication changes affecting mobility or cognition
	  ○ deterioration in physical or mental health leading to increased vulnerability
	• regulatory and policy compliance:
	  ○ updates to health and safety legislation
	  ○ revised workplace policies and best practice guidance
	• effectiveness of existing control measures:
	  ○ reviewing whether current precautions remain effective in preventing harm
	  ○ identifying gaps in procedures that require additional measures
	• training and awareness considerations:
	  ○ identifying staff competency gaps
	  ○ ensuring all staff understand and implement risk assessment updates
	• monitoring and continuous improvement:
	  ○ establishing formal review timelines
	  ○ adapting risk assessments as new risks or workplace changes occur.

2.3	**Accidents and emergencies in adult health and social care**

2.3.1	Risk factors leading to accidents and emergencies in adult health and social care settings:
	
	• common accidents and emergencies in care settings:
	  ○ slips, trips, and falls
	  ○ injuries from sharps
	  ○ fire incidents
	  ○ medical emergencies
	• environmental hazards:
	  ○ poor lighting
	  ○ cluttered walkways
	  ○ wet floors
	  ○ lack of grab rails
	  ○ electrical faults
	• human factors:
	  ○ poor mobility
	  ○ medication side effects
	  ○ confusion in service users
	  ○ challenging behaviour
	• equipment failures:
	  ○ faulty alarms
	  ○ malfunctioning medical devices
	  ○ electrical faults
	• lack of staff training:
	  ○ inadequate emergency response knowledge
	  ○ poor handling and disposal of medical equipment
	  ○ inadequate training on de-escalation techniques.

2.3.2	Applying emergency procedures in health and social care settings: • responding to accidents and emergencies: the AMEGA approach: ○ assess the situation – identify the severity of the incident

Teaching content:	
	○ make safe – remove immediate dangers where possible ○ emergency aid – apply first aid within scope of training ○ get help – alert emergency services or senior staff ○ aftercare – support service users, document the incident, and review for future improvements • use of on-site emergency equipment by trained staff: ○ correct selection and use of fire extinguishers ○ defibrillators (AEDs) ○ EpiPens ○ evacuation procedures ○ de-escalation techniques.
2.3.3	Strategies for preventing accidents and incidents in adult health and social care settings: • carry out risk assessments • reporting hazards • regular staff training • effective communication and documentation • spillage and clean-up procedures • safe handling of service users • fall prevention in care plans • clear safety signage: ○ fire exits ○ hazardous areas ○ chemical pictograms • temperature checks: ○ food is served at safe temperatures ○ bath water is checked to prevent burns • regular maintenance of equipment • reflective practice.
2.4	**Fire safety in adult health and social care settings**
2.4.1	Strategies for promoting fire safety in health and social care settings: • clear organisational accountability: • regular staff training: ○ fire safety awareness ○ fire drills ○ evacuation procedures • regular sharing of fire safety information with service users • checking visibility and accuracy of fire safety signage and literature • compliance with legislative and regulatory requirements.
2.4.2	Best practice for reducing the risk of fire in health and social care settings: • conduct fire risk assessments • implement training programmes: ○ fire marshal training ○ evacuations training • conduct regular fire drills and practice evacuations • regular testing and maintenance of fire alarms and detection systems • installation of fire doors and fire-resistant materials • correct placement, maintenance, and training for fire extinguishers • regular testing and maintenance of sprinkler system.

Teaching content:	

2.4.3	Applying fire safety procedures in health and social care settings:
	
	• recognising fire hazards and potential dangers to individuals
	• safeguard individuals and colleagues if safe to do so
	• use firefighting equipment only if trained:
	  ○ selecting the correct type of fire extinguisher:
	  ▪ water extinguisher – for wood, paper, or textiles
	  ▪ CO^2 extinguisher – for electrical fires
	  ▪ foam extinguisher – for flammable liquids
	• call 999 if the fire cannot be contained
	• contain fire if safe to do so by closing doors and windows to limit oxygen supply
	• implement evacuation plans using designated routes:
	  ○ fire warden coordinates movement to safety
	  ○ leave behind any personal belongings
	  ○ do not use escalators or lifts during evacuation
	  ○ personal emergency evacuation plans (PEEPs) activated for immobile individuals
	  ○ keep people in safe areas and two fire doors away from the fire if unable to evacuate
	• gather at the assembly point and wait for the emergency services to arrive
	• account for everyone in the building
	• provide first aid assistance if required
	• do not re-enter the building until authorised by emergency services
	• record actions, report fire incident, and review fire emergency plan after incident.

2.5	**Safe moving and handling in health and social care settings**

2.5.1	Risk factors in moving and handling in health and social care settings:
	
	• the individual's condition:
	  ○ physical impairments
	  ○ cognitive issues
	  ○ medical equipment
	• the task being performed:
	  ○ type of movement
	  ○ weight of the individual or object
	  ○ distance of movement required
	• the environment:
	  ○ floor conditions
	  ○ obstructions
	  ○ tight spaces restricting movement
	• staff competency and wellbeing:
	  ○ number of staff required
	  ○ staff fatigue or stress levels
	  ○ training and experience in manual handling.

2.5.2	Applying the principles of safe moving and handling in health and social care settings:
	
	• environment checks:
	  ○ flooring is dry and clutter-free
	  ○ adequate lighting
	  ○ space for movement
	• plan:
	  ○ consider precise task required
	  ○ plan the best technique before moving
	  ○ assess the need for mechanical aids
	  ○ consider the service users' comfort, dignity, and consent

Teaching content:	
	○ assess load ○ number of people required to carry out the task ○ plan route • carry out manual handling: ○ appropriate personal protective equipment (PPE) ○ correct manual handling techniques ○ maintain dignity of the individual ○ know own limits and capacity to carry out the task ○ do not carry out task without appropriate training ○ use equipment safely.
2.5.3	Application of safe moving and handling techniques in health and social care settings: • supporting individuals with mobility: ○ assisting a person to stand from a sitting or lying position: ▪ using correct posture and weight distribution to prevent strain ▪ encouraging the individual to assist where possible ○ supporting individuals to reposition in bed or a chair: ▪ using safe lifting techniques to reduce risk of injury ▪ avoiding unnecessary pressure on joints or fragile skin ○ helping a person to walk safely: ▪ providing steady support through proper positioning ▪ using mobility aids such as walking frames or canes correctly • transferring individuals between locations: ○ moving an individual using a wheelchair or hoist: ▪ ensuring the correct equipment is selected for the individual's needs ▪ applying safe techniques for transfers to avoid injury ○ using slide sheets or transfer boards: ▪ reducing friction and pressure on the body during transfers ▪ ensuring team coordination when using equipment • providing personal care safely: ○ supporting bathing, dressing, and toileting: ▪ maintaining dignity and privacy throughout the process ▪ adapting techniques for individuals with different needs ○ assisting individuals in using mobility aids and assistive equipment: ▪ supporting correct positioning for safety and comfort ▪ ensuring equipment is used as intended • handling equipment and household items safely: ○ moving medical equipment and furniture: ▪ using correct manual handling techniques to prevent strain ▪ checking for obstacles and planning the safest route ○ performing housekeeping tasks: ▪ following safe lifting and carrying techniques ▪ using appropriate tools and support to reduce physical strain.
2.5.4	The consequences of unsafe manual handling techniques and processes: • physical consequences: ○ for staff: ▪ cuts, bruises, muscle sprains, and strains ▪ short or long-term pain ▪ musculoskeletal disorders ▪ fractures and breaks ▪ repetitive strain injuries ○ for service user: ▪ falls leading to fractures, dislocations, or soft tissue injuries

Teaching content:	
	▪ pressure ulcers due to incorrect repositioning ▪ breathing difficulties if handled incorrectly ▪ discomfort or pain from rough or unskilled handling • psychological impact: ○ for staff ▪ anxiety and stress due to fear of injury or harming others ▪ low staff morale ▪ increased pressure from staff absence due to injury ○ for service user: ▪ loss of confidence ▪ emotional distress ▪ fear of future movements • impact on care delivery: ○ increased hospital admissions ○ long recovery times for service users after injury ○ reduced quality of care due to lower staff numbers, due to stress or injury ○ higher costs for setting: ▪ legal claims ▪ staff cover ▪ training.
2.5.5	Application of strategies to prevent accidents or injuries when carrying out manual handling tasks: • complete manual handling training • carry out regular risk assessments and update when necessary • agree number of staff needed to carry out specific tasks • use lifting aids or mechanical devices where available • reduce level of twisting and stooping • avoid lifting from floor level • complete regular visual checks on equipment, record and report any concerns.
2.6	**Hazardous substances in health and social care settings**
2.6.1	Risk factors and control measures for hazardous substances in health and social care settings: • types of hazardous substances: ○ cleaning agents ○ clinical waste ○ bodily fluids ○ medication ○ chemical waste ○ pressurised gas cylinders ○ used PPE • associated hazards and risks: ○ irritant ○ toxic ○ infectious materials ○ explosive ○ corrosive ○ flammable ○ environmental contamination • effects on health and wellbeing: ○ short-term effects: ▪ skin reactions

Teaching content:	
	▪ minor burns ▪ short-term respiratory issues ▪ infections from exposure to bodily fluids or contaminated materials ○ long-term effects: ▪ chronic respiratory conditions ▪ poisoning ▪ severe burns ▪ cancer risk • control measures: ○ store hazardous substances securely ○ ensure hazard labels are legible and accurate ○ appropriate PPE selection and use ○ follow correct disposal procedures using colour-coded bins, safe disposal of sharps and chemicals ○ ensuring all staff follow safety procedures for handling hazardous substances ○ conduct regular risk assessments and incident reporting.
2.6.2	Application of safe handling, storage, and disposal of hazardous substances in health and social care settings: • employer responsibilities: ○ conduct risk assessment ○ set policies and procedures that comply with regulations ○ provide suitable PPE ○ provide adequate training and instructions for product use and application ○ provide secure storage • employee responsibilities: ○ wear appropriate PPE ○ follow hygiene procedures ○ use equipment safely according to instructions ○ report any concerns.
2.7	**Infection control in health and social care settings**
2.7.1	The causes and transmission of infection in health and social care settings: • bacteria – single-celled organisms that multiply rapidly and cause infections: ○ common transmission routes: ▪ contaminated food ▪ poor hygiene ▪ airborne droplets ▪ cross-contamination of medical equipment ○ impact in setting: ▪ spreads rapidly in shared living spaces ▪ increases hospital admissions ▪ requires antibiotic treatment ▪ can lead to outbreaks requiring quarantine and deep cleaning • fungi – thrive in warm, moist environments: ○ common transmission routes: ▪ direct skin contact ▪ damp environments ▪ shared personal items ○ impact in setting: ▪ can be persistent and difficult to treat ▪ may require isolation ▪ can lead to secondary infections

Teaching content:	
	▪ airborne fungal spores can affect lung conditions • viruses – enter cells and use them to replicate, spreading infection: o common transmission routes: ▪ airborne droplets ▪ physical contact ▪ surfaces and shared objects ▪ bodily fluids o impact in setting: ▪ highly contagious and can spread rapidly ▪ increased staff absence ▪ can lead to outbreaks requiring quarantine and deep cleaning ▪ higher risk for vulnerable service users ▪ may require vaccination schedule • parasites – live inside or on a host, feeding on nutrients and causing harm: o common transmission routes: ▪ close physical contact ▪ insect bites ▪ contaminated food or water o impact in setting: ▪ difficult to diagnose which can delay treatment ▪ can cause malnutrition and serious health complications ▪ requires strict infection control during personal care.
2.7.2	Application of procedures to break the stages of the chain of infection (six links): • infectious agent– procedures to eliminate or reduce harmful microorganisms: o routine hand hygiene using soap and water or alcohol-based sanitiser o use of antimicrobial treatments where appropriate o cleaning and disinfecting contaminated equipment and surfaces o screening and monitoring for infections in care settings • reservoir or source – procedures to prevent the spread of infection from contaminated sources: o correct waste disposal of soiled dressings, bodily fluids, and sharps o safe food storage and preparation to prevent bacterial growth o environmental cleaning protocols • portal of exit – procedures to stop the pathogen leaving the infected source: o covering wounds and dressings properly to prevent fluid exposure o safe disposal of contaminated PPE o using respiratory hygiene measures o appropriate handling of bodily fluids using infection control procedures • mode of transmission– procedures to break the spread of infection between individuals: o hand hygiene before and after patient contact o use of barrier nursing techniques for contagious cases o regular cleaning of high-contact surfaces o safe handling and decontamination of laundry and equipment • portal of entry – procedures to protect against pathogens entering the body: o aseptic techniques in medical settings o use of PPE o wound care procedures to prevent infections from open injuries o vaccination of staff and service users to prevent entry of vaccine-preventable infections • susceptible host– procedures to protect those at higher risk of infection: o immunisation and health monitoring for vulnerable individuals o good nutrition and hydration to support immune system o reducing unnecessary antibiotic use to prevent resistance

Teaching content:	
	○ encouraging staff and service users to follow infection control procedures.
2.7.3	The impact of poor practice that can increase the spread of infection in a health and social care setting: • poor infection control practices: ○ poor hygiene ○ incorrect use of PPE ○ failure to use tissues/cover nose and mouth/wash hands when coughing and sneezing ○ incorrect disposal of waste ○ cross-contamination ○ lack of infection control training ○ failure to conduct appropriate risk assessment ○ no policies/procedures in place ○ failure to report infectious diseases • impact of poor infection control: ○ increased outbreaks ○ higher mortality rates in vulnerable service users ○ staff sickness ○ regulatory action.
2.8	**Preventing the spread of infection in health and social care settings**
2.8.1	Selection, use, and disposal of PPE in health and social care settings: • purpose of PPE in infection prevention: ○ creates a physical barrier to prevent transmission of infectious agents ○ protects staff and service users from cross-contamination ○ reduces exposure to hazardous substances ○ ensures compliance with legal and regulatory standards • types of PPE and their correct use: ○ gloves – used for handling bodily fluids, cleaning, and administering care ○ aprons and gowns – protect clothing from contamination ○ face masks and respirators – used to reduce airborne transmission risks ○ eye protection (goggles or face shields) – prevent exposure to splashes and airborne contaminants ○ footwear (overshoes, non-slip shoes) – prevent the spread of contaminants via floors • correct PPE application and removal (donning and doffing procedure): ○ donning (putting on PPE in correct order): ▪ hand hygiene ▪ apron or gown ▪ mask or respirator ▪ goggles or face shield (if required) ▪ gloves (last, ensuring cuffs cover the wrist) ○ doffing (safe removal of PPE to prevent contamination): ▪ remove gloves (pinch and peel method) ▪ remove apron/gown by folding it inward ▪ remove eye protection (if applicable) ▪ remove mask/respirator ▪ perform hand hygiene • safe disposal of PPE: ○ clinical waste bins – used PPE must be disposed of in appropriate colour-coded bins: ▪ yellow – highly infectious clinical waste

Teaching content:	
	▪ orange – infectious waste that can be treated before disposal ▪ black or clear – domestic/general waste ▪ purple – cytotoxic and cytostatic waste ▪ red – anatomical waste ▪ blue – pharmaceutical waste ○ preventing cross-contamination – used PPE should never be reused or placed on clean surfaces ○ staff accountability – PPE use should be monitored to ensure compliance.
2.8.2	Application of infection control measures in health and social care settings: • employer responsibilities: ○ adapting procedures based on infection risk level ○ ensuring infection control audits are conducted, recorded, and acted upon ○ implementing training strategies that monitor staff competency in infection control ○ enforcing disciplinary action where staff repeatedly fail to follow infection control policies • employee responsibilities: ○ adjusting infection prevention measures based on risk level ○ correct PPE donning and doffing ○ proper hand hygiene techniques ○ safe waste disposal: ▪ clinical waste ▪ general waste ▪ hazardous substances ○ regular deep cleaning of communal areas or high-touch surfaces ○ correct storage, handling, and preparation of food ○ isolating infected individuals when necessary, following national infection control policies ○ ensuring medical equipment is sterilised and stored correctly or disposed of ○ keeping indoor areas well-ventilated to reduce airborne transmission ○ ensuring all staff follow infection control protocols consistently ○ documenting and reporting infections to senior staff and regulatory bodies.
2.8.3	Applying infection risk assessments in practice: • identify infection risks based on setting type • conduct risk assessments that consider: ○ source of infection ○ mode of transmission ○ high-risk individuals ○ potential consequences if infection spreads • develop an infection control plan based on risk level, including: ○ modifying infection prevention strategies ○ enhancing decontamination protocols during outbreak scenarios ○ creating tailored risk reduction plans for individual service users.
2.8.4	The role and challenges of immunisation in health and social care settings: • prevents the spread of infectious diseases • reduces severity of illness for individuals who contract an infection • protects high-risk individuals, including: ○ elderly residents ○ immune-compromised individuals ○ unvaccinated individuals

Teaching content:	

	• reduces the burden on healthcare services
	• contributes to long-term disease control
	• supports infection control in care settings
	• challenges:
	  ○ vaccine uptake
	  ○ mutations and variations of virus
	  ○ misconceptions of vaccine safety
	  ○ cultural and religious beliefs
	  ○ access to immunisation programmes
	  ○ side effects.

2.9	**Decontamination and waste management practice**
2.9.1	Application and benefits of best practice for decontamination: • cleaning: removing visible dirt and debris to reduce the risk of infection • disinfection: using chemical disinfectants to kill most pathogens to prevent cross-contamination • sterilisation: eliminating all microorganisms from equipment and instruments to maintain a hygienic environment.

2.9.2	Application of safe waste disposal in health and social care settings:
	
	• types of waste that require controlled disposal:
	  ○ bodily fluids
	  ○ contaminated linen
	  ○ used PPE
	  ○ sharps
	  ○ infectious waste
	• correct waste disposal practices:
	  ○ colour-coded clinical waste bins
	  ○ segregation of contaminated materials
	  ○ safe handling of sharps and sharp containers
	  ○ proper disposal of chemical and pharmaceutical waste following COSHH regulations.

Unit 2: Assessment Approach

The mode of assessment used for this unit is a Non-examination Assessment (NEA). This assessment method is externally set by TQUK and internally marked by centres.

The NEA for an individual unit cannot commence until the unit content has been fully taught to learners and TQUK's mandatory standardisation training is completed.

An overview of the assessment approach is outlined in the table below:

Assessment description	The NEA comprises a brief designed to assess the learners' applied knowledge and skills and their ability to evidence critical analysis and reflective evaluation of the subject content.
Duration of NEA	The timeframe for the completion of the NEA is 10-12 hours
Assessment windows	The NEA brief is released in September each year. Centres have the flexibility in scheduling the NEA within the academic session but must ensure it is completed by 30 April at the latest to allow for marking, internal quality assurance, and external moderation activities

The Non-examination Assessment will be conducted under controlled assessment conditions.

Centres **must** refer to the Assessment Guidance for the Delivery of Alternative Academic Qualifications document, available on our website, to ensure the appropriate administration and marking of this assessment and adherence to TQUK regulations.

The NEA has been carefully aligned with the assessment objectives (AOs) to create a consistent framework for learners. The table below confirms the assessment objectives that will be covered in the Non-examination Assessment.

Assessment objective	Description
AO4a – Research and plan	Learners are able to **research**, **investigate,** and **plan** tasks, **choose** appropriate methods and actions
AO4b - Review skills, methods, and actions	Learners are able to **review** their skills, methods, and actions
AO5- Demonstrate and apply skills and methods relevant to the given sector	Learners are able to **demonstrate** their application of technical skills relevant to the sector by **applying** the appropriate processes, tools, and techniques

Unit 3: Equality, Diversity, and Inclusion in Health and Social Care

Unit Number:	R/651/5403		
Level:	3	**GLH:**	60
Unit Introduction:	Health and social care services must be accessible, inclusive, and free from discrimination. This unit explores the importance of promoting equality, diversity, inclusion, and equity, ensuring that all individuals receive fair and appropriate care. It examines key legislation such as the Equality Act 2010 and the Human Rights Act 1998, highlighting their role in protecting individuals' rights. The unit considers the impact of discrimination and barriers to accessing care, as well as the responsibilities of professionals in creating inclusive environments. The role of policies, organisational frameworks, and professional standards in promoting equality is also explored. By understanding the principles of inclusion, equity, and anti-discriminatory practice, this unit ensures that professionals can deliver person-centred care that respects individual needs, preferences, and cultural backgrounds.		
Assessment Type:	Examination Assessment (EA)		

Teaching content:	
3.1	**Legislation, policies, and procedures relating to equality, diversity, and inclusion**

3.1.1	The functions of legislation, policies, guidance, and organisations relating to equality, diversity, inclusion, and equity:
	
	• legislation:
	  ○ Equality Act 2010:
	  ▪ protects individuals from discrimination by defining protected characteristics
	  ▪ requires reasonable adjustments to ensure equal access to services and employment
	  ▪ ensures fair treatment in public services, workplaces, and healthcare
	  ○ Human Rights Act 1998:
	  ▪ establishes fundamental rights, including dignity, respect, and freedom from discrimination
	  ▪ Provides a legal basis to challenge unfair treatment in health and social care
	  ○ Mental Capacity Act 2005:
	  ▪ protects individuals who may lack decision-making capacity from discriminatory practices
	  ▪ ensures individuals are supported to make their own choices where possible
	  ▪ sets out best interest decision-making processes when capacity is impaired
	• policies, guidance, and organisations:
	  ○ Equal Opportunities Policy:
	  ▪ ensures fair and inclusive practices in employment and service delivery
	  ▪ prevents discrimination in recruitment, training, and career progression
	  ○ Dignity in Care Principles (SCIE, Care Act 2014):
	  ▪ provides best practice guidance on maintaining dignity and respect for service users
	  ▪ encourages person-centred care and respect for individual preference
	  ○ Code of Practice (Department of Health):

Teaching content:	
	▪ outlines professional expectations for inclusive, ethical, and person-centred care ▪ supports best practice in equality, diversity, and inclusion (EDI) compliance ○ Care Quality Commission (CQC) Standards: ▪ sets out essential standards for safe, compassionate, and high-quality care ▪ ensures that health and social care services promote dignity, equality, and respect • Organisations responsible for enforcing and promoting inclusion: ○ Equality and Human Rights Commission (EHRC): ▪ monitors compliance with equality laws and investigates breaches ▪ provides guidance and legal support for discrimination claims ○ NHS Equality and Diversity Council (EDC): ▪ oversees inclusion initiatives within the NHS and ensures equitable healthcare access ▪ ensures equitable healthcare access and workforce representation ○ Local Authorities: ▪ oversee the implementation of equality policies in public services ▪ provide support for inclusive social care services and funding.
3.2	**Equality, diversity, inclusion, and equity**
3.2.1	The meaning and application of equality, diversity, inclusion, discrimination, and equity in the context of adult health and social care: • equality: ○ meaning: ensuring individuals receive fair and equal treatment based on their specific needs ○ application: ▪ adjusting care plans to accommodate specific needs ▪ ensuring all service users receive the same quality of care, regardless of their background ▪ training staff to challenge unconscious bias in patient care • diversity: ○ meaning: recognising and valuing differences in culture, background, and experience while ensuring equal access to services ○ application: ▪ offering culturally appropriate meals in care settings ▪ supporting multilingual service users by providing translated health information ▪ employing a diverse workforce that represents different cultures and communities • inclusion: ○ meaning: enabling individuals to fully participate in society and care settings without barriers ○ application: ▪ providing accessible buildings and facilities for individuals with mobility impairments ▪ encouraging service users with learning disabilities to participate in decision-making about their care ▪ ensuring all staff and service users feel respected and valued through inclusive policies and training • discrimination: ○ meaning: unfair or prejudicial treatment based on individual characteristics, leading to exclusion or disadvantage ○ application:

Teaching content:	
	▪ challenging staff who treat elderly patients differently due to stereotypes about ageing ▪ addressing cases where individuals are refused care due to their gender identity or sexual orientation ▪ reporting instances where a service user is denied a treatment option due to their race or disability • equity: ○ meaning: providing resources and opportunities based on individual circumstances to reduce disparities and promote fairness ○ application: ▪ offering additional home visits for individuals with complex care needs rather than applying a 'one-size-fits-all' approach ▪ allocating more funding or specialist support to service users with higher needs ▪ ensuring individuals from disadvantaged backgrounds can access the same healthcare opportunities through financial support schemes.
3.2.2	The importance of cultural competency in adult health and social care settings: • cultural awareness: ○ recognising and respecting different cultural beliefs, values, and practices • cultural sensitivity: ○ adapting communication and care to avoid unintentional bias or offence • linguistic competency: ○ providing translation services or multilingual support to improve communication • cultural humility: ○ maintaining a continuous learning approach, avoiding assumptions about different cultures • training and education: ○ supporting staff with ongoing cultural competency training to ensure fair treatment • build trust: ○ ensuring service users from diverse backgrounds feel respected, valued, and included • improved access to resources: ○ making services more inclusive and accessible for all demographics.
3.2.3	The benefits and challenges of cultural competency in adult health and social care settings: • benefits: ○ improves health outcomes by addressing cultural needs ○ reduce health inequalities by ensuring equitable care ○ enhances service user satisfaction ○ increased workforce satisfaction • challenges: ○ cultural misunderstandings may lead to misinterpretation of customs or expectations ○ resource constraints may limit training, funding, or translation services ○ implicit bias may result in unrecognised prejudices affecting decision-making.
3.2.4	The types and impact of discrimination in health and social care: • prejudice: ○ negative assumptions or stereotypes leading to bias in treatment

Teaching content:	
	○ individuals may feel excluded, unheard, or treated unfairly ○ can affect communication and trust between service users and professionals • direct discrimination: ○ explicit unfair treatment based on protected characteristics ○ may result in denied services, poorer treatment, or exclusion from care plans • indirect discrimination: ○ policies or procedures that unintentionally disadvantage specific groups ○ individuals may struggle to access care or experience longer wait times ○ can lead to unequal healthcare outcomes • harassment: ○ unwanted behaviour creating an intimidating or hostile environment ○ can cause distress, fear, and reluctance to engage with health services • victimisation: ○ retaliation against individuals for raising discrimination concerns ○ deters staff and service users from reporting issues or seeking support ○ can contribute to a culture of silence and ongoing poor practice • impact of discrimination: ○ individuals may feel unable to challenge their care, reducing autonomy ○ leads to anxiety, depression, and increased stress ○ lack of fair treatment may lead to worsening medical conditions or avoidable health risks ○ service users may avoid seeking care, worsening long-term health outcomes ○ individuals may avoid engaging in care or community activities ○ those discriminated against may be at greater risk of exploitation and neglect.
3.2.5	Forms of discriminatory behaviour and how they manifest in practice in health and social care environments: • verbal: ○ derogatory remarks ○ offensive or dismissive language • physical: ○ exclusion from activities or service ○ refusal of support due to prejudice • mental/psychological: ○ ignoring service user concerns ○ dismissive or patronising tone or attitude ○ making assumptions about capabilities • neglect: ○ failing to provide adequate support due to bias • financial: ○ unequal access to funding or financial resources • bullying: ○ persistent negative treatment of an individual due to differences • inadequate care: ○ failing to consider cultural or personal needs in care plans • labelling/stereotyping: ○ making generalised assumptions about individuals.
3.2.6	The application of the protected characteristics of the Equality Act 2010 in adult health and social care settings: • age: ○ ensures fair access to care services for individuals across all age groups ○ prevents age-based discrimination in treatment decisions

Teaching content:	
	○ supports age-appropriate care planning for older adults and younger service users • gender reassignment: ○ ensures inclusive and non-discriminatory healthcare for transgender individuals ○ requires staff to use correct pronouns and respect identity to uphold dignity ○ reduces barriers to accessing care due to stigma or lack of staff training • married or in a civil partnership: ○ prevents discrimination in spousal rights and next of kin decision-making ○ ensures that partners are involved in care planning and have legal recognition ○ supports equal treatment of married/civil partners in financial and legal matters in care settings • pregnancy or maternity: ○ ensures reasonable adjustments for pregnant service users or staff ○ protects against discrimination in employment and access to services during pregnancy ○ supports safe environments for new mothers, including maternity leave policies • disability: ○ requires reasonable adjustments to meet accessibility needs ○ promotes equal access to healthcare, employment, and services ○ protects individuals from being denied care or opportunities due to disability • race, including colour, nationality, and ethnicity: ○ ensures culturally appropriate care that considers diverse needs ○ prevents racial discrimination in treatment decisions or employment practices ○ supports language access services for non-native speakers in healthcare • religion or belief: ○ ensures culturally sensitive care that respects religious beliefs ○ requires staff to accommodate dietary, spiritual, and end-of-life care preferences ○ prevents faith-based discrimination in service provision and workplace policies • sex: ○ protects individuals from gender-based discrimination in healthcare ○ ensures equal opportunities in employment, career progression, and pay parity ○ supports gender-sensitive healthcare services • sexual orientation: ○ prevents discrimination against LGBTQ+ service users and staff ○ ensures equal access to healthcare, housing, and social care services ○ encourages inclusive policies and training to challenge biases.
3.3	**How inclusive practice supports equality and diversity in adult health and social care**
3.3.1	The impact of principles on inclusive practice: • person-centred care – understanding and respecting individual beliefs, culture, values, needs, and preferences: ○ ensures care is person-centred and aligns with individual rights ○ reduces the risk of discrimination by tailoring care to diverse needs • equality and non-discrimination – promoting the rights of the individual: ○ strengthens legal compliance with the Equality Act 2010 and Human Rights Act ○ supports dignity, autonomy, and self-determination • diversity and inclusion – valuing diversity and inclusion: ○ encourages equal opportunities regardless of background or identity ○ recognises the benefits of diverse perspectives in decision-making • accessibility – enabling access to services: ○ reduces social and physical barriers that limit service engagement ○ ensures all individuals have equal opportunities to receive care • empowerment and informed choice – providing accurate information and advice: ○ supports informed decision-making, leading to greater independence

Teaching content:	
	○ helps individuals access the right support at the right time • participation and social inclusion – encouraging active participation in social and community activities: ○ prevents isolation and promotes emotional wellbeing ○ increases an individual's sense of purpose and belonging • self-esteem and confidence –strengthening self-esteem and confidence: ○ supports individuals in recognising their abilities and developing self-worth ○ empowers individuals to take ownership of their care and personal growth.
3.3.2	The role of inclusive practice in improving quality of care: • enhancing holistic wellbeing: ○ recognises the connection between physical, emotional, and social health ○ supports personalised care planning to address all aspects of an individual's needs • creating a welcoming and accessible care environment: ○ increases service user trust and engagement ○ improves the overall experience of care services • encouraging meaningful participation: ○ helps individuals feel heard, valued, and included in decision-making ○ enhances empowerment by involving individuals in care planning • reducing loneliness and isolation: ○ nurtures social connections, particularly for individuals with limited family or community support ○ supports mental wellbeing and reduces the risk of depression • removing barriers to inclusion: ○ adapts services to support individuals with: ▪ language needs ▪ physical needs ▪ cultural needs • challenging bias and stereotyping in care settings: ○ ensures care professionals examine unconscious biases in decision-making ○ reduces assumptions that may impact the quality of care received • building a collaborative and inclusive workplace culture: ○ supports teamwork and staff diversity in care settings ○ encourages open communication and shared learning to improve inclusivity • balancing individual rights with safeguarding: ○ promotes autonomy while ensuring individuals are protected from harm ○ recognises that inclusion does not mean ignoring risks to health and safety • challenges in applying inclusive practice: ○ staff may struggle to tailor care due to workload ○ some professionals may lack training or awareness of inclusion strategies ○ systemic issues may prevent equitable access to services.
3.3.3	The effectiveness of inclusive practice in promoting equality and supporting diversity: • enhancing holistic wellbeing: ○ recognises the connection between physical, emotional, and social health ○ supports personalised care planning to address all aspects of an individual's needs • creating a welcoming and accessible care environment: ○ increases service user trust and engagement ○ improves the overall experience of care services • encouraging meaningful participation: ○ helps individuals feel heard, valued, and included in decision-making

Teaching content:	
	○ enhances empowerment by involving individuals in care planning • reducing loneliness and isolation: ○ fosters social connections, particularly for individuals with limited family or community support ○ supports mental wellbeing and reduces the risk of depression • removing barriers to inclusion: ○ adapts services to support individuals with: ▪ language needs – providing interpreters or translated materials ▪ physical needs – ensuring wheelchair accessibility and mobility support ▪ cultural needs – respecting religious beliefs and traditions • challenging bias and stereotyping in care settings: ○ ensures care professionals examine unconscious biases in decision-making ○ reduces assumptions that may impact the quality of care received • building a collaborative and inclusive workplace culture: ○ supports teamwork and staff diversity in care settings ○ encourages open communication and shared learning to improve inclusivity • balancing individual rights with safeguarding: ○ promotes autonomy while ensuring individuals are protected from harm ○ recognises that inclusion does not mean ignoring risks to health and safety • challenges in applying inclusive practice: ○ staff may struggle to tailor care due to workload ○ some professionals may lack training or awareness of inclusion strategies ○ systemic issues may prevent equitable access to services.
3.3.4	The relationship between inclusive practice and respecting an individual's beliefs, culture, values, and preferences: • beliefs (examples include religion, faith, diet, medical treatment): ○ shapes an individual's healthcare choices and attitudes toward medical interventions ○ impacts daily care considerations, such as food preparation and end-of-life care • culture (examples include traditions, identity, communication): ○ helps build trust between service users and professionals by acknowledging cultural practices ○ reduces misunderstandings and miscommunication that may impact care • values (examples include personal priorities and rights): ○ ensures individuals receive care that aligns with their personal convictions ○ supports ethical care decisions that respect the individual's wishes • preferences (examples include gender identity, lifestyle choices): ○ allows individuals to express their identity without fear of discrimination ○ encourages healthcare providers to adapt services to meet personal needs.
3.3.5	The function of leadership and management in embedding inclusive practice: • establishing organisational commitment: ○ creating and enforcing EDI policies ○ setting expectations for inclusive behaviour ○ allocating resources for training and development • accountability and oversight: ○ ensuring compliance with Equality Act 2010 and CQC regulations ○ leading investigations into discrimination complaints ○ reviewing staff and service user feedback on inclusion • promoting workforce diversity: ○ encouraging fair hiring and promotion practices ○ supporting leadership diversity to improve representation • training and role modelling:

Teaching content:	
	○ providing mandatory training on unconscious bias and cultural competency ○ ensuring all staff understand their responsibilities regarding inclusive practice • monitoring impact: ○ conducting internal audits and reports to track EDI effectiveness ○ using service user feedback to improve inclusion strategies.
3.3.6	The purpose of the introduction of the 6Cs in relation to equality, diversity, inclusion and equity: • The 6Cs in relation to equality, diversity, inclusion, and equity: ○ care – ensures all individuals receive safe, high-quality, and person-centred care, reducing discrimination ○ compassion – encourages sensitivity to cultural and personal differences, promoting inclusivity ○ competence – supports continuous professional development to improve culturally competent care ○ communication – ensures language, accessibility, and inclusive communication are considered ○ courage – encourages staff to challenge discrimination and inequality in practice ○ commitment – embeds equality, diversity, and inclusion into professional care standards • introduced in response to failings at Mid Staffordshire NHS Trust: ○ developed as a framework to refocus healthcare on patient-centred values ○ aims to address issues of neglect, poor care, and lack of compassion • ensures healthcare professionals combine emotional intelligence with technical skills: ○ strengthens the balance between clinical ability and ethical care delivery ○ prevents discrimination by emphasising personalised, dignified care • enhances professional accountability: ○ ensures staff take responsibility for meeting equality and inclusion standards ○ encourages continuous reflection on personal attitudes and biases • challenges in implementing the 6Cs: ○ some organisations may struggle with adopting patient-centred models ○ professionals may find it difficult to apply all 6Cs due to time constraints ○ care providers may lack funding or training to fully implement inclusive practices.
3.4	**Promotion and support of equality, diversity, inclusion, and equity in adult health and social care**
3.4.1	Barriers to equality, diversity, inclusion, and equity that can impact individuals who require care or support: • financial inequality: ○ limited access to private healthcare services ○ may prevent individuals from affording additional support, therapy, or assistive devices • mental health conditions: ○ stigma may prevent individuals from seeking help or being taken seriously ○ misunderstanding of symptoms may lead to discrimination or inappropriate treatment • discrimination: ○ implicit or explicit bias can affect the quality of care received ○ individuals may avoid engaging with services due to fear of judgement or exclusion • barriers to accessing services: ○ limited public transport or lack of nearby services ○ inability to afford transport, medication, or treatment ○ long waiting lists or lack of specialist support

Teaching content:	

	• physical barriers:
	  ○ inaccessible buildings, lack of ramps, and inadequate facilities for wheelchair users
	  ○ poorly designed healthcare settings may prevent full participation in care decisions
	• cognitive barriers:
	  ○ complex medical jargon and inaccessible communication styles
	  ○ lack of interpreters or easy-read materials
	• abuse as a barrier:
	  ○ individuals may be isolated and prevented from seeking support
	  ○ poor workplace culture, staff attitudes, or failure to uphold equality policies
	  ○ discrimination or exclusion due to unconscious bias.

3.4.2	Strategies to challenge discrimination in a way that promotes change:
	
	• creating an inclusive workplace culture:
	  ○ leadership commitment to challenging discrimination and promoting diversity
	  ○ encouraging open discussions to address unconscious bias
	• policies and procedures:
	  ○ clear reporting mechanisms for discrimination complaints
	  ○ regular policy reviews to ensure best practice in equality and inclusion
	• awareness and education:
	  ○ staff training on equality, diversity, and unconscious bias
	  ○ accessible posters, leaflets, and online resources to promote awareness
	• encouraging communication and vigilance:
	  ○ active monitoring of discrimination within the workplace
	  ○ creating safe spaces for individuals to share concerns without fear of retaliation
	• providing mentoring and role models:
	  ○ senior staff members leading by example in challenging discrimination
	  ○ offering guidance to new staff or those unsure of how to address issues.

3.4.3	Strategies to support others in promoting equality, diversity, equity, and inclusion:
	
	• organisational strategies:
	  ○ policies and procedures ensuring consistent practice in all settings
	  ○ training programmes to educate staff on inclusive working methods
	  ○ team meetings and forums to discuss equality-related concerns
	• individual strategies:
	  ○ 1-to-1 support for individuals facing discrimination or exclusion
	  ○ mentoring and coaching to empower staff and service users
	  ○ role modelling inclusive behaviours in daily interactions
	• information, advice, and guidance:
	  ○ providing accessible information about rights and available support
	  ○ connecting individuals with advocates or support networks
	• individuals who may require support:
	  ○ team members and colleagues
	  ○ service users
	  ○ family and carers
	  ○ advocates.

3.4.4	The impact of applied equity in adult health and social care settings:
	
	• positive impacts:
	  ○ reflects person-centred approaches – care is tailored to individual needs
	  ○ improves accessibility and fairness – removes barriers and reduces discrimination

Teaching content:	
	○ supports organisational goals – meeting key performance indicators (KPIs) and service level agreements (SLAs) ○ ensures compliance with legislation – avoids legal consequences and enhances reputation • challenges and resource implications: ○ differentiated support may increase costs ○ on-going education is required to maintain best practice ○ potential resistance to change from staff and service users.

Unit 3: Assessment Approach

The mode of assessment used for this unit is an Examination Assessment (EA). This assessment method is externally set and marked by TQUK, ensuring consistency and reliability in the evaluation of a learner's knowledge and understanding.

An overview of the assessment approach is outlined in the table below:

Assessment description	The EA comprises a balance of multiple-choice questions (MCQs), extended-response questions (ERQs), and short-answer questions (SAQs).
Assessment windows	Late January/early February** and early May Centres have the flexibility to timetable the Examination Assessment within the specified assessment window.
Duration of EA	1 hour 30 minutes

** **Important**: in the first year of delivery, there is no assessment window opportunity in January 2027. Thereafter, EAs will be available annually in late January/early February and mid-May.

The Examination Assessment will be conducted under exam conditions in a controlled environment. Centres must refer to the Assessment Guidance for the Delivery of Alternative Academic Qualifications document available on our website for further information to support the administration of the EA.

The assessment has been carefully aligned with the unit's assessment objectives (AOs) to create a consistent framework for learners. The table below confirms the assessment objectives that will be covered in the Examination Assessment.

Assessment objective	Description
AO1 – Recall knowledge and information	Learners are to **recall** knowledge and information
AO2 – Apply knowledge and information	Learners are to **apply** knowledge and information to situations and contexts relevant to the given sector
AO3 – Interpret, analyse or evaluate information, ideas, or different viewpoints	Learners are able to **interpret**, **analyse,** or **evaluate** information, ideas, or different viewpoints to make **judgements** that are reasoned or draw conclusions.

Unit 4: Safeguarding in Adult Health and Social Care

Unit Number:	T/651/5404		
Level:	3	**GLH:**	60
Unit Introduction:	Protecting individuals from harm is a key responsibility for all health and social care professionals. This unit explores safeguarding legislation, policies, and procedures that ensure adults at risk are protected from abuse, neglect, and exploitation. It examines the role of the Care Act 2014, the Mental Capacity Act 2005, and the Disclosure and Barring Service (DBS) in safeguarding practice. The unit also considers different types of abuse and their warning signs, along with the responsibilities of professionals in recognising, reporting, and responding to safeguarding concerns. Multi-agency working is explored, demonstrating how organisations such as social services, the police, and healthcare providers collaborate to prevent and address abuse. By understanding safeguarding principles, this unit ensures professionals can apply best practices to protect individuals while respecting their rights, promoting wellbeing, and supporting independence.		
Assessment Type:	Non-examination Assessment (NEA)		

Teaching content:	
4.1	**Legislation, policies, and procedures in safeguarding**

4.1.1	The use of legislation, policies, and procedures in guiding safeguarding practices in adult health and social care:
	
	• The Care Act 2014 – section 42-47:
	  ○ establishes legal duties for local authorities in adult safeguarding
	  ○ defines "adults at risk" and outlines how to manage concerns
	  ○ sets out the requirement for Safeguarding Adults Reviews (SARs) after serious incidents
	• Human Rights Act 1998 – 16 human rights (specifically rights 2, 3, 5, 6):
	  ○ protects individuals from inhumane or degrading treatment
	  ○ ensures individuals have the right to life and liberty
	  ○ used to challenge safeguarding failures in court
	• The Equality Act 2010:
	  ○ protects against discrimination in care services
	  ○ ensures services make reasonable adjustments for disabilities
	  ○ mandates that safeguarding must uphold individual rights
	• The Mental Health Act 1983:
	  ○ allows individuals to be detained for assessment or treatment if a risk is identified
	  ○ safeguards decision-making capacity for those with mental health conditions
	• The Health and Social Care Act 2012:
	  ○ introduced a new regulatory framework for NHS and social care services
	  ○ requires CQC-regulated settings to follow safeguarding procedures
	  ○ established Health and Wellbeing Boards to oversee local safeguarding priorities
	• The Health and Care Act 2022:
	  ○ amended the 2012 Act, strengthening integration between health and social care
	  ○ established Integrated Care Systems (ICS) to improve safeguarding coordination

Teaching content:	
	○ placed new duties on the CQC to assess local authority adult social care responsibilities • Sexual Offences Act 2003: ○ protects individuals from sexual exploitation and abuse ○ introduces specific offences for abuse in care settings • Safeguarding Vulnerable Groups Act 2006: ○ defines the Disclosure and Barring Service (DBS) process ○ ensures safe recruitment practices by barring individuals from care roles • Mental Capacity Act 2005: ○ provides guidance on decision-making for adults who may lack capacity ○ defines Deprivation of Liberty Safeguards (DoLS) to prevent unnecessary restrictions • Public Interest Disclosure Act 1998: ○ protects whistleblowers reporting safeguarding concerns ○ encourages staff to challenge unsafe practice without fear of dismissal • application of policies and procedures to safeguarding: ○ whistleblowing policy: ▪ enables staff to report abuse or misconduct ▪ protects whistleblowers from retaliation ○ safeguarding policy: ▪ outlines how concerns should be recorded and reported ▪ details how safeguarding referrals should be handled ○ Social Care Institute for Excellence (SCIE) safeguarding guidance: ▪ establishes best practice for risk management ▪ guides practitioners on prevention strategies ▪ provides a legal framework for professionals to follow ○ making safeguarding personal: ▪ ensures safeguarding is person-centred and respects individual autonomy ▪ requires tailored interventions rather than a one-size-fits-all approach ○ adult safeguarding boards: ▪ coordinates multi-agency safeguarding responses ▪ oversees investigations and case reviews ▪ provides training and professional development for safeguarding leads.
4.2	**Safeguarding Responsibilities in Adult Health and Social Care**
4.2.1	The principles of 'safeguarding' and 'adults at risk' in practice: • safeguarding: ○ protecting an individual from abuse, neglect, and improper treatment ○ preventing impairment of individual's health or development ○ ensuring an individual is provided with consistent, safe, and effective care • adult at risk: ○ an individual aged 18 or over who may require additional support or protection due to: ▪ mental or physical disability ▪ chronic illness or frailty ▪ inability to care for themselves or protect themselves from harm or exploitation.
4.2.2	Application of safeguarding in adult health and social care settings: • implement safeguarding in practice: ○ conduct regular safeguarding audits to ensure compliance ○ hold safeguarding briefings for service users to raise awareness

Teaching content:	
	○ introduce real-life safeguarding scenarios in staff training for practical understanding ○ carry out spot checks to assess how safeguarding policies are applied in daily care ○ ensuring service users understand their rights and how to report abuse • safe recruitment practices: ○ disclosure and barring service (DBS) checks to prevent unsuitable individuals from working in care settings ○ verification of qualifications and references before employment ○ rigorous interview and vetting processes • ongoing staff training and professional development: ○ regular safeguarding training and CPD ○ supervision and performance monitoring to ensure staff compliance ○ providing safeguarding support for staff in challenging situations • policies and procedures that protect service users and staff: ○ clear safeguarding policies outlining reporting and response protocols ○ whistleblowing policies allowing staff to raise concerns safely ○ lone working policies reducing risk in one-to-one care ○ risk management strategies ensuring proactive safeguarding measures.
4.2.3	The role and responsibilities of multi-agency safeguarding in protecting adults at risk of abuse and neglect: • the role of multi-agency safeguarding in improving safeguarding outcomes: ○ prevents gaps in protection by ensuring agencies share concerns ○ information-sharing protocols improve decision-making ○ holistic safeguarding approach ○ allows for faster intervention to reduce harm • responsibilities of key multi-agency safeguarding organisations: ○ Care Quality Commission (CQC) – regulatory body ensuring compliance with safeguarding standards ○ Social Services – lead agency for safeguarding adults at risk and coordinating care assessments ○ Police – investigate safeguarding concerns where criminal offences may have been committed ○ health and social care professionals – identify and report safeguarding concerns in practice ○ Designated Safeguarding Leads (DSLs) – ensure organisational compliance with safeguarding policies ○ Safeguarding Adults Boards (SABs) – oversee local safeguarding arrangements and conduct case reviews • practical applications of multi-agency safeguarding: ○ referral pathways and escalation procedures for safeguarding concerns ○ multi-agency meetings and case conferences for complex safeguarding cases ○ collaborative safeguarding training for unified responses across agencies • challenges of multi-agency safeguarding in practice: ○ confidentiality and data-sharing concerns ○ delays due to agency bureaucracy ○ conflicting priorities between different sectors (for example, healthcare versus social care) ○ resource constraints and staffing shortages affecting response times.

Teaching content:	

4.2.4	The steps taken when applying Safeguarding Adults Reviews (SARs) in multi-agency safeguarding:
	
	• key steps in conducting a SAR:
	  ○ referral and decision to undertake a SAR
	  ○ gathering information from involved agencies and professionals
	  ○ reviewing safeguarding actions, records, and case history
	  ○ establishing a review panel to examine lessons learned
	  ○ publishing findings and recommendations to prevent future safeguarding failures
	  ○ monitoring and evaluating safeguarding improvements following a SAR.

4.3	**Duty of care in adult health and social care**

4.3.1	Role and importance of duty of care in professional practice:
	
	• definition of duty of care:
	  ○ legal and professional responsibility to keep people safe and promote wellbeing
	  ○ ensuring actions prioritise safety and ethical standards
	• why duty of care is essential:
	  ○ prevents harm, negligence, and unsafe practices
	  ○ ensures legal and professional accountability
	• challenges in upholding duty of care:
	  ○ balancing autonomy and safeguarding
	  ○ resource limitations impacting care
	  ○ managing confidentiality versus reporting concerns.

4.3.2	Applying the principles of duty of care in professional practice:
	
	• key principles of duty of care in professional practice:
	  ○ following guidance, policies, and procedures to ensure compliance with best practices
	  ○ treating people with dignity and respect in all interactions
	  ○ participating in training to maintain up-to-date skills and knowledge
	  ○ keeping accurate records of all aspects of an individual's care
	  ○ working within own capabilities to prevent errors or unsafe practice
	  ○ raising concerns about standards of care where necessary
	  ○ working in partnership with service users, families, colleagues, and other professionals
	• safeguarding responsibilities within duty of care:
	  ○ ensuring service users receive safe, person-centred care
	  ○ preventing neglect, harm, or abuse through proactive safeguarding measures
	  ○ recognising potential safeguarding risks and taking appropriate action
	  ○ upholding ethical and legal responsibilities when safeguarding concerns arise
	  ○ applying risk assessment strategies to reduce safeguarding risks
	  ○ documenting safeguarding actions to ensure accountability and compliance.

4.3.3	Applying duty of care when balancing individual rights with safeguarding responsibilities:
	
	• applying safeguarding decisions while respecting autonomy:
	  ○ applying the Mental Capacity Act (2005) in decision-making
	  ○ ensuring safeguarding actions align with best interest decisions
	  ○ balancing confidentiality with the need to share safeguarding information
	  ○ using professional judgement to determine the level of intervention needed
	• applying the Caldicott Guardian principles in safeguarding:
	  ○ justifying the purpose of sharing safeguarding information

Teaching content:	
	○ using the minimum necessary personal data ○ ensuring only relevant professionals have access to safeguarding information ○ following legal and ethical frameworks when handling confidential information ○ balancing the duty of care with the right to privacy for service users • practical considerations in duty of care and safeguarding: ○ managing ethical dilemmas where an individual refuses intervention ○ deciding when to override an individual's wishes for their protection ○ ensuring proportionate responses that respect the individual's rights ○ handling disclosures of abuse sensitively while following legal procedures.
4.4	**Recognising and responding to signs of abuse in adult health and social care**
4.4.1	Types of abuse and their indicators in adult health and social care: • physical: ○ bruising or unexplained physical injuries ○ burns ○ weight loss ○ fear and anxiety • sexual: ○ preoccupation with anything sexual ○ unexpected change in behaviour ○ sore in genital area ○ torn or stained underwear • emotional: ○ depression ○ fear ○ sleep deprivation ○ changes in behaviour • financial: ○ unpaid bills ○ unusual bank account activity ○ shortage of money ○ lack of food • institutional: ○ inflexible systems and processes ○ inconsideration of dietary requirements ○ discriminatory remarks ○ lack of self-care • neglect: ○ malnutrition ○ confusion ○ bedsores ○ untreated medical issues • self-neglect ○ disinterest in own appearance ○ losing weight ○ lack of personal hygiene ○ hoarding • discriminatory: ○ being refused access or excluded ○ resistance to access services ○ anxious ○ withdrawn • domestic: ○ bruising or physical injury

Teaching content:	
	○ clothing/make-up to hide injuries ○ withdrawn and unwilling to engage in conversation ○ afraid or anxious • modern slavery: ○ substance misuse ○ unkempt or malnourished ○ workplace used for accommodation ○ distrustful of those in authority • mate/hate crime: ○ take advantage through pretend friendship ○ asks for or takes money from an individual on pretext of being their friend ○ often violent and as a result of prejudice because of an individual's social or racial demographic • cyberbullying and catfishing: ○ secretiveness/unwillingness to share details of online activity ○ changes in sleep pattern ○ upset after being online ○ avoids face-to-face contact.
4.4.2	Risk factors that increase vulnerability to abuse: • emotional factors: ○ phobias ○ anxiety ○ depression ○ low self-esteem • cognitive factors: ○ special educational needs ○ learning disabilities ○ autism ○ dementia ○ onset of mental ill health • social factors: ○ isolation ○ poverty ○ lack of support network • physical factors: ○ medical conditions ○ disabilities ○ increasing frailty due to ageing • environmental factors: ○ low staffing levels ○ institutional bias or neglect ○ leadership issues.
4.4.3	Applying best practice when responding to a disclosure: • providing initial support: ○ remain calm and reassure the individual ○ offer active listening and emotional support ○ follow appropriate communication techniques: ▪ avoid leading questions or suggesting answers ▪ encourage the individual to share at their own pace ▪ clarify and gather information • emergency safeguarding interventions: ○ contact emergency services if there is an immediate risk of harm

Teaching content:	
	○ inform designated safeguarding leads (DSL) or safeguarding adults' teams within the organisation ○ implement urgent safeguarding measures, such as removing the individual from immediate danger ○ avoid confronting the alleged abuser if present • implement safeguarding protocols: ○ assess urgency and escalate if required ○ understand when and how to share safeguarding information responsibly ○ document disclosures accurately, including date, time, and verbatim statements ○ inform relevant safeguarding leads or external agencies, following local policies.
4.4.4	Strategies to mitigate potential barriers to disclosure of abuse: • build trust with individuals through consistency and openness • ensure individuals understand their rights in a safeguarding situation • provide accessible ways for individuals to report concerns: ○ advocacy services ○ independent support • reduce stigma around reporting by creating a safe and supportive environment.
4.4.5	Apply safeguarding interventions and support systems: • long-term safeguarding support: ○ refer individuals to social services for ongoing assessment and care planning ○ engage with advocacy services to support individuals in expressing their needs and rights ○ develop individual safeguarding plans, ensuring continued protection and recovery support • embedding safeguarding within organisational policies: ○ conduct regular safeguarding reviews to assess effectiveness ○ provide ongoing safeguarding training for staff ○ implement confidential reporting procedures to encourage disclosure • multi-agency safeguarding collaboration: ○ work with local authorities, police, and health services to create coordinated safeguarding plans ○ attend case conferences and strategy meetings to manage ongoing safeguarding risks ○ ensure safeguarding leads engage with regulatory bodies like the Care Quality Commission (CQC) for oversight.
4.4.6	Application of evidence preservation to ensure compliance in safeguarding cases: • preserving evidence: ○ avoid handling or contaminating evidence ○ preserve forensic evidence where possible ○ ensure chain of custody is maintained for legal and safeguarding compliance ○ report and secure any digital evidence • accurate record keeping: ○ maintain detailed, factual records of disclosures and safeguarding concerns ○ use verbatim recording where possible for disclosure statements ○ sign and date records upon completion ○ securely store documentation in compliance with GDPR and data protection policies ○ follow legal and organisational safeguarding policies to support formal investigations.

Teaching content:	

4.4.7	Applying preventative safeguarding measures to reduce the likelihood of abuse:
	
	• proactive safeguarding strategies in practice:
	  ○ regularly reviewing and updating risk assessments to identify safeguarding risks early
	  ○ embedding safeguarding training in CPD programmes to ensure continuous professional development
	  ○ establishing clear whistleblowing and reporting procedures so staff can report concerns safely
	  ○ strengthening safeguarding policies and governance structures to reinforce best practice
	• applying safeguarding in person-centred care:
	  ○ involving individuals in their care planning and decision-making processes
	  ○ educating individuals about their rights and how to recognise and report abuse
	  ○ ensuring accessibility of safeguarding procedures for individuals with learning disabilities, sensory impairments, or communication needs
	• implementing multi-agency collaboration for prevention:
	  ○ strengthening information-sharing protocols between safeguarding professionals
	  ○ conducting multi-agency training sessions to ensure unified safeguarding approaches
	  ○ engaging safeguarding partners to prevent abuse before it occurs.

4.5	**Recognise and report unsafe practices**

4.5.1	Recognising and responding to unsafe practices in adult health and social care:
	
	• supporting professionals in identifying unsafe practices:
	  ○ implementing whistleblowing policies and procedures to protect staff who report concerns
	  ○ encouraging peer review to maintain high professional standards and accountability
	  ○ promoting open and transparent reporting to prevent safeguarding failures
	  ○ providing supervision and CPD to equip staff with the skills to recognise unsafe practices
	  ○ conducting regular risk assessments to proactively identify potential harm
	  ○ embedding reflective practice to assess and improve safeguarding approaches
	  ○ carrying out audits and compliance monitoring to review practices and ensure safeguarding responsibilities are met
	  ○ creating a culture of open communication, ensuring staff feel safe to raise concerns without fear of retaliation
	• implementing best practice when responding to unsafe practices:
	  ○ following whistleblowing policies and safeguarding legislation to ensure concerns are handled in line with professional and legal responsibilities
	  ○ taking immediate safeguarding actions when an individual is at risk, ensuring safety is prioritised
	  ○ reporting incidents promptly to safeguarding leads, local authorities, or regulatory bodies such as the Care Quality Commission (CQC)
	  ○ implementing corrective measures to address failings in safeguarding procedures and prevent further risk
	  ○ maintaining accurate safeguarding records to ensure transparency, accountability, and compliance
	  ○ monitoring and reviewing safeguarding procedures to continually improve and adapt to emerging risks
	  ○ updating policies, procedures, and training guidance to reflect lessons learned from incidents and best practice reviews.

Teaching content:	

4.5.2	Applying escalation procedures when unsafe practices are not addressed:
	
	• escalating concerns to senior management if internal reporting is ineffective
	• liaising with local authority safeguarding teams for additional support
	• reporting to external regulators such as:
	  ○ Care Quality Commission (CQC) for regulatory breaches
	  ○ Health and Safety Executive (HSE) for workplace safety concerns
	• contacting emergency services for urgent safeguarding risks
	• engaging with Safeguarding Adults Boards (SABs) for case reviews
	• following whistleblowing protections to ensure professionals can report concerns safely
	• involving advocacy services to support individuals affected by unsafe practices.

Unit 4: Assessment Approach

The mode of assessment used for this unit is a Non-examination Assessment (NEA). This assessment method is externally set by TQUK and internally marked by centres.

The NEA for an individual unit cannot commence until the unit content has been fully taught to learners and TQUK's mandatory standardisation training is completed.

An overview of the assessment approach is outlined in the table below:

Assessment description	The NEA comprises a brief designed to assess the learners' applied knowledge and skills and their ability to evidence critical analysis and reflective evaluation of the subject content.
Duration of NEA	The timeframe for the completion of the NEA is 8-10 hours
Assessment windows	The NEA brief is released in September each year. Centres have flexibility in scheduling the NEA within the academic session but must ensure it is completed by 30 April at the latest to allow for marking, internal quality assurance, and external moderation activities

The Non-examination Assessment will be conducted under controlled assessment conditions.

Centres **must** refer to the Assessment Guidance for the Delivery of Alternative Academic Qualifications document, available on our website, to ensure the appropriate administration and marking of this assessment and adherence to TQUK regulations.

The NEA has been carefully aligned with the assessment objectives (AOs) to create a consistent framework for learners. The table below confirms the assessment objectives that will be covered in the Non-examination Assessment.

Assessment objective	Description
AO4a – Research and plan	Learners are able to **research**, **investigate,** and **plan** tasks, **choose** appropriate methods and actions
AO4b – Review skills, methods, and actions	Learners are able to **review** their skills, methods, and actions
AO5 – Demonstrate and apply skills and methods relevant to the given sector	Learners are able to **demonstrate** their application of technical skills relevant to the sector by **applying** the appropriate processes, tools, and techniques

Unit 5: The Person-Centred Approach in Health and Social Care

Unit Number:	Y/651/5405		
Level:	3	**GLH:**	60
Unit Introduction:	Providing high-quality care means focusing on the needs, preferences, and experiences of individuals. This unit explores the principles of person-centred care, ensuring that individuals are involved in decisions about their treatment and support. It examines key frameworks such as the Care Act 2014 and the Mental Capacity Act 2005, highlighting their role in promoting choice, dignity, and independence. The unit considers how professionals can apply person-centred approaches in different care settings, ensuring that care is tailored to individuals' physical, emotional, and social needs. The importance of effective communication, advocacy, and partnership working is also explored, demonstrating how professionals can support individuals to express their views and make informed choices. By understanding the person-centred approach, this unit ensures that professionals can deliver care that upholds dignity, respects individual rights, and promotes wellbeing across health and social care settings.		
Assessment Type:	Non-examination Assessment (NEA)		

Teaching content:	
5.1	**Legislation, policies, and procedures**

5.1.1	The function of legislation, policies, and frameworks relating to the person-centred approach:
	
	• legislation:
	  ○ The Care Act 2014:
	  ▪ introduces the principle of wellbeing, ensuring care planning prioritises individual needs
	  ▪ strengthens personal budgets and direct payments, allowing individuals greater control over their care
	  ▪ requires advocacy support for those unable to express their wishes independently
	  ○ The Health and Social Care Act 2012:
	  ▪ reinforces patient choice and personalisation in care delivery
	  ▪ emphasises integrated care models, where services are shaped around individual preferences
	  ○ Mental Capacity Act 2005 & Deprivation of Liberty Safeguards (DoLS):
	  ▪ establishes the presumption that individuals have capacity to make their own decisions unless proven otherwise
	  ▪ introduces best interest decision-making processes when individuals lack capacity
	  ▪ ensures deprivation of liberty is only used when necessary and proportionate to the individual's needs
	  ○ The Equality Act 2010:
	  ▪ enforces equal treatment in care provision
	  ▪ requires reasonable adjustments to meet the diverse needs of individuals
	  ○ The Human Rights Act 1998:

Teaching content:	
	▪ protects the right to dignity, respect, privacy, and autonomy in care decisions ▪ supports individuals' rights to legally challenge poor person-centred practice ○ The NHS Constitution (England) 2015: ▪ ensures service users are involved in decisions about their care ▪ mandates that healthcare professionals deliver care with respect and compassion • policies guiding person-centred practice: ○ advocacy policy ensures individuals who need support in decision-making have access to independent advocates ○ safeguarding policy protects individuals from harm while maintaining their right to make informed choices ○ whistleblowing policy enables staff to challenge poor person-centred care without fear of repercussions ○ person-centred care policy sets expectations for tailored support plans and holistic care approaches ○ personal care policy ensures individual preferences, dignity, and comfort are respected in care routines • frameworks supporting person-centred care: ○ 6C's – Compassion in Practice Strategy (NHS): ▪ defines key values that underpin caring and person-centred practice ○ Person-Centred Approach Framework (2017) – Skills for Care: ▪ provides guidance for health and social care professionals on embedding person-centred values in daily practice ▪ encourages co-production, where individuals are active participants in shaping their care ○ Health and Care Professions Council (HCPC) – Standards of Conduct, Performance, and Ethics: ▪ establishes the expectation that care professionals should prioritise individual needs and preferences ▪ reinforces the importance of communication, respect, and shared decision-making in person-centred care.
5.2	**The person-centred approach**
5.2.1	Key concepts when embedding person-centred values in practice: • co-production: ○ enabling individuals to have an active role in their care decisions, ensuring voice, control, and rights are central • application of person-centred values: ○ ensuring care is tailored to the individual's needs, preferences, and aspirations • applied personalisation: ○ adapting services and empowering individuals to direct their own support • decision-making autonomy: ○ supporting individuals to make choices about their lives and care • understanding the difference between wants and needs: ○ balancing personal preferences with essential care requirements • living a meaningful life: ○ ensuring care promotes wellbeing, engagement, and personal fulfilment • equal partnership: ○ recognising individuals, professionals, families, and support networks as key contributors to care decisions • legislative awareness: ○ ensuring practice aligns with the Care Act 2014, Equality Act 2010, Mental Capacity Act 2005, and Human Rights Act 1998.

Teaching content:	
5.2.2	The benefits of embedding person-centred values across adult health and social care: • empowers service users to have greater control over decisions regarding their care • supports independence in self-care, autonomy, and choice • promotes dignity and ensures individuals feel valued • upholds human rights and legal protections • improves quality of life by promoting engagement and wellbeing • enables flexible and responsive care that adapts to changing needs • ensures compliance with legal and regulatory frameworks • facilitates self-directed care by allowing individuals to manage their own care funding • strengthens relationships between service users, professionals, and support networks.
5.2.3	Implementing and managing person-centred care plans in practice: • conduct initial and ongoing assessments: o identify individual needs, preferences, and aspirations through structured reviews o assess and document changes in physical, emotional, cognitive, and social wellbeing o ensure assessments align with strengths-based approaches that focus on abilities rather than limitations • developing and structuring personalised care plans: o translate assessments into care plans that reflect individual goals and preferences o balance personal choices with risk management and safety considerations o ensure care plans comply with legal and regulatory frameworks o clearly document care plans and ensure accessibility for all involved professionals • monitoring and adapting care plans: o conduct regular care plan reviews to ensure ongoing suitability o adjust care strategies in response to changing needs, input from professionals, and service user feedback o collaborate with multi-agency professionals to ensure continuity of care.
5.2.4	Strategies for implementing and adapting a person-centred approach: • promoting autonomy and self-management: o encourage individuals to take ownership of their care through education and skills development o implement assistive technologies to enhance independence and accessibility o apply risk management strategies that balance safety with personal choice and freedom • applying co-production strategies to improve services: o establish peer-support networks to enable individuals to share experiences and provide input o involve service users in shaping policies, training, and decision-making through advisory panels o support individuals in contributing to staff development to promote inclusive care practices • enhancing communication and collaboration: o apply shared decision-making models to engage individuals in care choices o use accessible formats such as visual aids, communication boards, and advocacy services

Teaching content:	
	○ promote equal partnerships between individuals, professionals, families, and support networks in decision-making.
5.2.5	Approaches to managing complex or sensitive situations using a person-centred approach: • importance of person-centred values in challenging situations: ○ ensures individuals feel heard, valued, and respected even in distressing situations ○ reduces stress and anxiety for the individual and professionals ○ promotes emotional safety and helps maintain trust in care relationships • considerations when approaching complex situations: ○ the individual's previous experiences with care and decision-making ○ level of emotional distress and potential trauma-informed care approaches ○ risk of escalation and the need for de-escalation strategies ○ communication barriers that may impact understanding and cooperation • strategies for person-centred approaches in sensitive scenarios: ○ apply compassion and active listening to validate concerns and emotions ○ use non-verbal cues and alternative communication methods if needed ○ adapt responses based on the individual's care plan and risk management strategies ○ offer privacy and create a calm environment to reduce stress ○ promote autonomy by supporting self-expression and choice ○ ensure support is collaborative by involving multi-disciplinary teams when appropriate ○ follow relevant policies and procedures to maintain professional and ethical standards.
5.2.6	The role of monitoring and adapting person-centred care in response to changing needs: • importance of continuous monitoring in person-centred care: ○ enables care professionals to identify early signs of change in needs and preferences ○ ensures interventions remain effective, appropriate, and responsive ○ avoids potential deterioration in health, wellbeing, or independence • factors that necessitate care adaptations: ○ physical changes: ▪ mobility decline ▪ new disability ▪ medication adjustments ○ emotional or cognitive changes: ▪ mental health fluctuations ▪ dementia progression ○ environmental or social changes: ▪ loss of a caregiver ▪ relocation • adapting approaches while maintaining person-centred values: ○ apply a flexible and evolving care plan rather than a rigid model ○ involve the individual and support network in all decision-making processes ○ ensure multi-agency collaboration to streamline adjustments ○ implement clear communication strategies so all professionals are aligned ○ regularly review and reflect on care approaches to identify further improvements.
5.2.7	Integrating feedback from individuals, families, and professionals: • structured feedback mechanisms:

Teaching content:	
	○ conduct regular care reviews with input from individuals and their support networks ○ implement real-time feedback mechanisms such as digital platforms or care logs ○ establish multi-agency case conferences to discuss evolving needs and care effectiveness • apply feedback to improve service delivery: ○ conduct regular care reviews with input from individuals and their support networks ○ implement real-time feedback mechanisms such as digital platforms or care logs ○ establish multi-agency case conferences to discuss evolving needs and care effectiveness • create action plans for continuous improvement: ○ convert feedback into measurable objectives for service development ○ embed service user input into training sessions to address gaps in inclusivity and accessibility ○ ensure feedback-related changes are documented and evaluated for long-term impact.
5.3	**Establishing consent when providing care or support in adult health and social care**
5.3.1	The principles of valid consent in person-centred care: • consent as a fundamental right in health and social care: ○ ensures dignity, respect, and autonomy for individuals receiving care ○ reinforces legal and ethical responsibilities under the Mental Capacity Act 2005 and Human Rights Act 1998 ○ promotes person-centred care by involving individuals in decisions about their care • key principles of valid consent: ○ capacity and competence: the individual must be able to understand and retain information to make an informed choice ○ voluntary decision-making: consent must be given freely, without coercion or pressure ○ adequate information: the individual must receive clear, relevant, and accessible information to make a choice ○ informed understanding: the person must fully comprehend the consequences of their decision.
5.3.2	Methods to establish consent in practice: • verbal consent: ○ seeking direct confirmation through conversation or discussion ○ checking for understanding before proceeding • written consent: ○ documenting agreement in care plans or medical records ○ signed agreements for treatment, medical procedures, or care plans • implied consent: ○ observing an individual's actions, gestures, or cooperation to infer agreement ○ ensuring non-verbal cues indicate understanding and willingness • alternative communication strategies: ○ using visual aids, sign language, or accessible formats for those with communication barriers ○ involving interpreters, advocates, or family members to support the individual in decision-making.
5.3.3	Factors that create barriers to gaining consent:

Teaching content:	

	• cognitive and mental health barriers:
	  ○ severe learning disabilities, dementia, or acquired brain injury affecting decision-making
	  ○ mental health conditions that impair judgement
	• physical barriers:
	  ○ long-term conditions (for example, chronic illness, disability, or mobility limitations)
	  ○ short-term conditions (for example, acute illness, injury, shock, fatigue, or medication side effects)
	• communication and information barriers:
	  ○ language barriers, jargon, or complex terminology
	  ○ lack of accessible formats
	  ○ overwhelming or insufficient information preventing informed decision-making
	• environmental and situational barriers:
	  ○ noisy or crowded environments that affect concentration
	  ○ stressful or high-pressure situations limiting an individual's ability to process information
	  ○ lack of privacy, reducing an individual's willingness to communicate openly
	• personal and emotional barriers:
	  ○ an individual's personality, mood, or past traumatic experiences influencing their ability to consent
	  ○ fear of consequences or coercion from others, leading to reluctance in decision-making.

5.3.4	Strategies to use if consent cannot be readily established:
	
	• adapt communication to match the individual's needs:
	  ○ use simplified language, visual aids, interpreters, or alternative communication methods
	  ○ offer additional time and breaks to avoid overwhelming the individual
	• modify the environment:
	  ○ reduce noise and distractions to promote focus and engagement
	  ○ ensure privacy to support open and informed decision-making
	• reassess at a different time:
	  ○ if the individual is unwell, anxious, or fatigued, wait until they are in a better state to provide consent
	  ○ allow time for reflection and follow up later
	• involve appropriate professionals or advocates:
	  ○ seek input from family members, carers, or independent advocates where appropriate
	  ○ work with healthcare professionals to clarify concerns and ensure support
	• use observational methods:
	  ○ recognise non-verbal cues that may indicate consent or refusal
	  ○ encourage the individual to express preferences in their preferred way
	• follow Mental Capacity Act 2005 guidance if capacity is in doubt:
	  ○ ensure a decision-specific capacity assessment is completed
	  ○ provide all necessary support before determining if the individual lacks capacity
	  ○ ensure assessments are conducted by an appropriate professional
	• if the individual lacks capacity, apply 'best interest' decision-making:
	  ○ involve multi-disciplinary teams and consult relevant policies and legislation
	  ○ consider the individual's previously expressed wishes and values
	  ○ maintain a formal record of decisions made and the rationale
	• respect the individual's right to refuse care:
	  ○ if the individual has capacity, their decision must be upheld even if it differs from professional recommendations

Teaching content:	
	○ document refusals and provide opportunities for future discussions • ensure documentation and compliance: ○ record all actions taken, including assessments, discussions, and decisions ○ follow organisational policies and legal frameworks for safeguarding and consent.
5.4	**Implement and promote active participation**
5.4.1	Implementing active participation in practice: • encouraging communication and shared decision-making: ○ provide information in accessible formats ○ support the individual to express their preferences using their preferred communication method ○ facilitate open discussions to ensure service users' voices are central in decisions about their care ○ use active listening techniques to validate concerns and promote understanding • empowering individuals through choice and autonomy: ○ offer a range of choices and involve individuals in setting personal goals ○ support positive risk-taking within safe parameters to build independence ○ encourage individuals to take an active role in self-management of care and daily living activities.
5.4.2	Promoting active participation as a collaborative approach: • collaboration with individuals and support networks: ○ involve families, advocates, or social networks to reinforce participation and decision-making ○ recognise and respect cultural, religious, and personal preferences when promoting engagement ○ use multi-agency working to tailor participation strategies to complex care needs • creating enabling environments for participation: ○ identify and remove barriers to participation (for example, physical, emotional, or cognitive challenges) ○ provide access to adaptive resources to support engagement (for example, communication aids, accessibility tools) ○ promote person-centred approaches that embed: ▪ dignity ▪ respect ▪ inclusion ▪ flexible support frameworks.
5.5	**Supporting an individual's right to make choices**
5.5.1	Strategies to support an individual to make informed choices: • use an individual's preferred method of communication to present information • apply key person-centred values: ○ dignity ○ rights ○ respect • provide clear and balanced advice on the potential consequences of decisions, including "unwise" choices • offer practical decision-making tools, such as risk assessments, to support informed choices

Teaching content:	
	• encourage partnership working with advocates, families, or professionals to reinforce decision-making.

5.5.2	Strategies to empower an individual to question or challenge decisions made by others:
	
	• create an environment where individuals feel safe to challenge decisions:
	  ○ provide a safe and supportive space for open discussions
	  ○ encourage individuals to express concerns without fear of retaliation
	  ○ offer guidance on how to gather information about the decision being challenged
	• support strategies:
	  ○ discuss alternative solutions and explore different care options
	  ○ advocate on the individual's behalf if requested, ensuring their voice is heard
	  ○ provide access to complaints procedures and support individuals through the process
	  ○ ensure the individual has access to their care records and documentation to support informed decisions
	  ○ involve the individual in meetings and discussions about their care
	  ○ educate individuals on their legal rights to challenge decisions.

5.5.3	The impact and management of others' personal views on an individual's choices:
	
	• impact of others' personal views on an individual's choices:
	  ○ personal beliefs or biases from family, caregivers, or professionals may influence an individual's decisions
	  ○ external views can lead to coercion or undue pressure, restricting an individual's right to make their own choices
	  ○ decisions influenced by others can result in:
	  ▪ abuse
	  ▪ breach of human rights
	  ▪ discrimination
	• strategies to manage external influence and promote independent choice:
	  ○ encourage self-expression to ensure individuals feel safe articulating their own preferences
	  ○ identify and challenge coercion where individuals appear hesitant, fearful, or unable to make choices freely
	  ○ use advocacy services to support individuals in making independent and informed decisions
	  ○ educate caregivers and professionals on respecting choice and avoiding imposing personal values
	  ○ ensure decision-making aligns with legislation
	  ○ Implement safeguarding measures where undue influence restricts an individual's rights.

5.6	**Promoting an individual's wellbeing**

5.6.1	Strategies to support an individual's identity, self-image, and self-esteem:
	
	• supporting an individual's sense of identity:
	  ○ recognise and respect cultural values, beliefs, and preferences in care planning
	  ○ encourage self-expression by involving individuals in decision-making about their care, appearance, and lifestyle
	  ○ provide opportunities for individuals to explore their purpose and sense of belonging through community engagement and personal development activities
	• enhancing self-image in a care setting:

Teaching content:	
	○ support individuals in maintaining their personal appearance and self-care routines according to their preferences ○ encourage positive body image and self-perception through personalised care approaches ○ ensure individuals feel valued and seen by recognising their achievements and contributions • promoting self-esteem and emotional wellbeing: ○ adopt an inclusive, supportive, and encouraging environment to empower individuals ○ enable individuals to develop confidence through setting achievable goals and celebrating progress ○ implement therapeutic interventions such as positive reinforcement, counselling, or peer support ○ reduce social isolation by encouraging meaningful social interactions and relationships.
5.6.2	Applying key factors that contribute to an individual's wellbeing in health and social care practice: • key factors contributing to an individual's wellbeing: ○ spiritual wellbeing: providing opportunities for religious, cultural, or personal reflection ○ physical wellbeing: ensuring access to healthcare, nutrition, and physical activity ○ social wellbeing: facilitating social interactions, reducing isolation, and supporting engagement in community activities ○ emotional wellbeing: supporting mental health, providing emotional support, and creating safe environments ○ financial wellbeing: offering guidance on financial support options, ensuring access to benefits or resources ○ cultural and religious wellbeing: ensuring individuals have the freedom to practise their faith, traditions, or cultural identity ○ political wellbeing: enabling individuals to participate in society, vote, and express their views where applicable • applying Maslow's hierarchy of needs to wellbeing: ○ physiological: ensuring individuals have access to food, hydration, and a safe living environment ○ safety: protecting individuals from harm, providing stable and secure care settings ○ love and belonging: developing meaningful relationships, emotional support, and social inclusion ○ esteem: recognising achievements, supporting self-worth, and promoting independence ○ self-actualisation: enabling individuals to pursue personal goals and a meaningful life • practical applications in health and social care: ○ conduct holistic wellbeing assessments to identify individual needs ○ create personalised wellbeing plans that incorporate emotional, social, and physical factors ○ encourage participation in wellbeing-focused activities such as creative therapies, exercise, or mindfulness ○ integrate wellbeing strategies into care plans to ensure a proactive and person-centred approach.

Unit 5: Assessment Approach

The mode of assessment used for this unit is a Non-examination Assessment (NEA). This assessment method is externally set by TQUK and internally marked by centres.

The NEA for an individual unit cannot commence until the unit content has been fully taught to learners and TQUK's mandatory standardisation training is completed.

An overview of the assessment approach is outlined in the table below:

Assessment description	The NEA comprises a brief designed to assess the learners' applied knowledge and skills and their ability to evidence critical analysis and reflective evaluation of the subject content.
Duration of NEA	The timeframe for the completion of the NEA is 6-8 hours
Assessment windows	The NEA brief is released in September each year. Centres have flexibility in scheduling the NEA within the academic session, but must ensure it is completed by 30 April at the latest to allow for marking, internal quality assurance, and external moderation activities

The Non-examination Assessment will be conducted under controlled assessment conditions.

Centres **must** refer to the Assessment Guidance for the Delivery of Alternative Academic Qualifications document, available on our website, to ensure the appropriate administration and marking of this assessment and adherence to TQUK regulations.

The NEA has been carefully aligned with the assessment objectives (AOs) to create a consistent framework for learners. The table below confirms the assessment objectives that will be covered in the Non-examination Assessment.

Assessment objective	Description
AO4a – Research and plan	Learners are able to **research**, **investigate,** and **plan** tasks, **choose** appropriate methods and actions
AO4b - Review skills, methods, and actions	Learners are able to **review** their skills, methods, and actions
AO5- Demonstrate and apply skills and methods relevant to the given sector	Learners are able to **demonstrate** their application of technical skills relevant to the sector by **applying** the appropriate processes, tools, and techniques

Section 3: Assessment and Achievement

Assessment Objectives and Weightings

The assessment objectives for the qualification are set out below and provide the basis for the assessment of each unit.

- AO1, AO2, and AO3 are assessed through Examination Assessments (EAs)
- AO4 and AO5 are assessed through Non-examination Assessments (NEAs).

The following table outlines the overall weightings of each assessment objective across the qualification.

	Assessment Objective	Weighting
EA	AO1 Recall knowledge and information Learners are able to recall knowledge and information.	4%
	AO2 Apply knowledge and information Learners are able to apply knowledge and information to questions, problems, or scenarios.	18%
	AO3 Interpret, analyse or evaluate information, ideas or different viewpoints Learners are able to interpret, analyse, or evaluate information, ideas, or different viewpoints to make judgements that are reasoned or draw conclusions.	18%
NEA	AO4a Research and plan AO4b Review skills, methods, and actions Learners are able to research, investigate, and plan tasks, choose appropriate methods and actions, as well as review these skills, methods, and actions.	26%
	AO5 Demonstrate and apply skills and methods relevant to the given sector Learners are able to demonstrate their application of technical skills relevant to the sector by applying the appropriate processes, tools, and techniques.	34%

In Examination Assessments, the primary focus is on applying knowledge, interpreting, and analysing information.

In Non-examination Assessments, the weighting is more balanced between research, planning, review, and the demonstration of sector-relevant skills and methods.

This table details how marks are allocated across the assessment objectives in each assessment.

	AO1	AO2	AO3	AO4a	AO4b	AO5
Unit 1	11%	45%	44%			
Unit 2				33%	11%	56%
Unit 3	10%	42%	48%			
Unit 4				43%		57%
Unit 5				43%		57%

Assessment Adaptation

Centre adaptation of the Examination Assessment or Non-examination Assessment is **not permitted**. This is to ensure that the qualification as a whole, and each associated assessment task, retains its reliability and comparability across centres and learners. TQUK has taken the approach of externally setting the assessments to ensure that each learner has a fair opportunity to achieve the qualification.

Grading and Marking

Grading and aggregation

The grading structure for the qualification comprises Pass, Merit, and Distinction for the component assessments and Pass, Merit, Distinction, and Distinction* for the overall qualification grade.

TQUK will use a Uniform Mark Scheme (UMS) to aggregate grades. The standard for a pass will be decided by a minimum mark, which is correlated to a UMS. The UMS will be able to factor in variations across unit achievement and over time to ensure comparability across mark ranges and assessment series.

Each assessment will be marked against raw marks, and at the awarding meeting, cut scores for each of the grade boundaries for pass, merit, and distinction will be decided. These will then be converted into the UMS for that unit. The UMS for each unit will then be aggregated into a qualification grade.

The qualification follows a compensatory grading model, meaning that marks from different assessments are aggregated. Learners do not need to achieve a minimum mark in individual units, as the final qualification grade is based on the total UMS marks gained across all assessments.

Each unit assessment contributes a set percentage to the final qualification grade. The total UMS score for the qualification is 500 marks, with assessments, weightings, and marks as follows:

Unit	Assessment method	Weighting	Raw Marks	UMS marks
Unit 1	EA 90 GLH	24%	75	120
Unit 2	NEA 90 GLH	24%	72	120
Unit 3	EA 60 GLH	16%	50	80
Unit 4	NEA 60 GLH	18%	56	90
Unit 5	NEA 60 GLH	18%	56	90
			309	500

The overall percentage grading scale for each unit is:

Grade	%
Not Yet Achieved	0-39%
Pass	40-59%
Merit	60-79%
Distinction	80-100%

Grade boundaries

The grade boundaries for the UMS for each unit are as follows:

Unit	Pass	Merit	Distinction
Unit 1	48	72	96
Unit 2	48	72	96
Unit 3	32	48	64
Unit 4	36	54	72
Unit 5	36	54	72

Learners' final grades for the qualification are determined using the following UMS boundaries:

Grade	Boundary
Not Yet Achieved	0-199
Pass	200-299
Merit	300-399
Distinction	400-449
Distinction*	450-500

The grade of Distinction* will be awarded at **qualification level only** to learners scoring marks of 450 and above overall.

Aggregation for the award of the qualification will be based on the sum of marks awarded for the UMS across all the units, and awards will be made in line with the qualification grade thresholds. There will be no minimum expectation within units as the qualification is fully compensatory.

These UMS grade boundaries ensure consistency across assessment series while allowing for adjustments in raw mark thresholds, which are finalised in the awarding meeting.

A grading calculator is available to support centres in calculating final grades. This can be downloaded from TQUK's management system, Verve.

Marking approach

The qualification follows a structured marking approach designed to ensure that learners are assessed consistently across all qualification outcomes. This approach rewards learners for demonstrating their knowledge, understanding, and skills, providing a fair and reliable indication of their achievement.

The marking system allows for full compensation, meaning that there is no minimum threshold of achievement required within individual assessments. Learners can demonstrate a broad range of knowledge and skills across the qualification, making their final grade a meaningful indicator of ability for higher education institutions and employers.

This approach also supports assessors in differentiating between different levels of performance within units. It provides a detailed and accurate measure of learner achievement while balancing positive and negative variations in assessment performance, ensuring that the final aggregated mark reflects a learner's overall ability.

Examination Assessments are marked using a combination of points-based and levels-based mark schemes, depending on the type of question and level of demand. For example:

- multiple-choice questions (MCQs) are marked using a points-based system.
- short-answer questions (SAQs) and extended response questions (ERQs) are marked using a levels-based approach.

The examination paper is designed to align with the assessment objective weightings, ensuring that knowledge recall, application, and evaluation skills are measured appropriately.

Non-examination Assessments are marked using a levels-based approach with four distinct mark bands. This structure provides a clear and consistent way for assessors to differentiate between levels of performance. The four-band system helps prevent grades clustering at the Merit level (known as 'regression to the mean') and instead ensures that learners are more reliably placed within the grading structure of Pass, Merit, or Distinction. Please refer to the Assessment Guidance for the Delivery of the Alternative Academic Qualifications for full marking guidance.

Once raw marks have been assigned, they are converted into the Uniform Mark Scheme (UMS), ensuring that final grades remain fair and comparable across different assessment series.

This marking approach ensures that all assessments provide a robust, valid, and fair measure of learner performance, supporting progression to further study or employment.

Awarding meeting and grade boundary setting

TQUK will hold an awarding meeting following each assessment session to determine grade boundaries for the qualification. The awarding meeting is a critical part of the quality assurance process, ensuring that results are fair, reliable, and comparable across different assessment sessions.

During the judgemental review, the committee will independently review learner work for all units at Pass, Merit, and Distinction, focusing on mark ranges identified within each grade boundary.

While the grading scale and UMS boundaries have been pre-set, the actual raw mark cut scores may vary from series to series based on assessment difficulty.

The awarding meeting will use statistical analysis and expert judgement to review learner performance. If an assessment is found to be more or less challenging than expected, the raw mark boundaries may be adjusted to ensure fairness and consistency.

Once awarding activities, including internal scrutiny, are completed, TQUK will:

- convert raw marks to UMS marks for each unit.
- apply unit grades based on UMS scores.
- determine the final qualification grade for each learner based on their aggregated UMS score.

TQUK will issue the AAQ results for the full qualification at the end of Year 2 to coincide with A Level results in August and within our standard certification timeframe following the post-results appeals period.

Grade descriptors

TQUK will use the following performance descriptors to indicate the level of attainment overall across the qualification.

Grade	Descriptor
Pass	Learners show adequate recall and communication of the basic elements of much of the content being assessed. They can apply their knowledge and understanding to some basic and familiar questions, problems, or scenarios. Responses to higher-order tasks involving detailed evaluation and analysis are often limited. Research, investigation, and planning of tasks are executed effectively but lack refinement, and the demonstration and application of skills and methods will produce often functional outcomes. More advanced skills and processes might be attempted, but not always executed successfully. Learners will be able to review their skills, methods, and actions, but this may lack a detailed reflection or analysis.
Merit	Learners show good recall and communication of many elements of the content being assessed. They can sometimes develop and apply their knowledge and understanding to different questions, problems, or scenarios, including some that are more complex or less familiar. Responses to higher-order tasks involving detailed evaluation and analysis are likely to be mixed, with good examples at times and others that are less detailed. Research, investigation, and planning of tasks are executed effectively, and the demonstration and application of skills and methods, including those that are more advanced, are developed in range and quality. Outcomes are good quality as well as being functional. Learners will be able to review their skills, methods, and actions with good application of reflection and analysis.
Distinction	Learners show thorough recall and communication of most elements of the content being assessed. They can consistently develop and apply their knowledge and understanding to different questions, problems, or scenarios, including those that are more complex or less familiar. Responses to higher-order tasks involving detailed evaluation and analysis are mostly successful. Research, investigation, and planning of tasks are executed effectively, and the demonstration and application of skills and methods, including those that are more advanced, are well-developed and executed. Outcomes are mostly of high quality. Learners will be able to review their skills, methods, and actions with consistent and thorough application of reflection and analysis.
Distinction*	Learners show comprehensive recall and communication of the content being assessed. They can develop and apply their knowledge and understanding to a range of complex or less familiar questions, problems, or scenarios. Research, investigation, and planning of tasks are comprehensively demonstrated, and the demonstration and application of skills and methods, including those that are complex, are highly developed and executed. Outcomes are consistently highly developed and executed. Learners will be able to comprehensively review their skills, methods, and actions with a comprehensive application of reflection and analysis.

Resits, Retakes, and Resubmissions

The qualification includes resit, retake, and resubmission opportunities, with availability determined by the mode of assessment and specific assessment stipulations.

Resit (EA only)

Learners are permitted resit opportunities for Unit 1 and Unit 3 Examination Assessments (EA) as outlined in the table below:

	Year 1 May	Year 2 Jan	Year 2 May
Unit 1	First sit	Resit	Resit
Unit 3	X	First sit	Resit

Once the learner has sat the EA, their completed paper cannot be amended or improved. When the EA result is released, if a learner wishes to improve their mark, they must do so by resitting a new EA in a subsequent assessment series.

The highest mark achieved will be used to calculate the final grade.

Centres must discuss the resit process with their learners and consider any practical implications.

Retake (NEA only)

Learners may refine specific elements of their completed NEAs based on the internal feedback they receive. This provides them with a **retake** opportunity. The retake must take place **before** the final submission of the NEAs for external moderation. This process allows learners to improve their submissions, but any feedback given to them must be documented and retained by the centre. Once an NEA is submitted for external moderation, no further changes can be made to it.

Resubmission (NEA only)

A **resubmission**, in contrast to a retake, occurs **after** external moderation has taken place, with **one** resubmission opportunity permitted per NEA brief (Units 2, 4, and 5).

Only learners who receive a 'Not Yet Achieved' (NYA) outcome following moderation are eligible to resubmit their NEA.

If a learner wishes to resubmit, they will be given 50% of the original supervised assessment time to complete the work for resubmission. This must be submitted by 14 June to ensure that the external moderation process is completed before final grades are awarded.

If a learner has exhausted both submission attempts on the same NEA project brief (retake and resubmission) and their evidence is graded 'Not Yet Achieved', they must complete the next live NEA project brief in the following session. In the event of a learner receiving an NYA grade, the marks achieved will count towards the overall grade.

Reviews and Appeals

TQUK is committed to ensuring any decisions it makes remain fair, reliable, and provide accurate and comparable results; however, we recognise that there may be situations where an individual wishes to appeal a decision or judgement TQUK has made.

Centres may appeal the results of the NEA moderation process. If a centre has concerns about the moderation of a cohort, it must request a review for all learners within that cohort. Written consent from all affected learners is required for the appeal to proceed.

Full details of the appeals process, including reviews of moderation, can be found in the Appeals Policy on our website.

Section 4: The NEA Moderation Process

The moderation process ensures that assessment decisions are fair, consistent, and aligned with national standards to ensure the qualification's integrity.

In line with JCQ (Joint Council for Qualifications) regulations, our moderation process ensures that assessors have applied our marking criteria accurately across all centres and learners.

The process involves standardisation activities, the sampling of learner work, and a review of the centre-assessed marks allocated to NEA completion.

Internal standardisation and training

To maintain consistency in our assessment approach, all centres must complete standardisation training between 1 October and 28 February before marking begins. Training on administrative processes is available via Verve, with completion confirmed on conclusion of the standardisation training. Centres must sign and submit a declaration to TQUK to confirm adherence to this policy. Standardisation materials, including exemplar assessments, will be accessible from September each year.

Submission of marks and moderation

Centres must submit the learner marks awarded for the NEAs via the TQUK Portal by 30 April each year.

On 1st May, (or the next working day if this date falls on a weekend or Bank Holiday), TQUK will release to centres the list of the learners selected for moderation.

The moderation sample will be selected following the submission of all centre marks and will include learners with the lowest and highest marks and a balanced range of learners between these points. Centres are not allowed to select their own learner sample for moderation.

The moderation sample size requested adheres to JCQ sampling guidelines and will be determined by the size of the learner cohort as outlined in the table below:

Number of Learners in Cohort	Sample Size Stage 1	Sample Size Stage 2	Sample Size Stage 3
Up to 5	All	All	All
6-10	5	All	All
11-15	6	10	All
16-100	6	10	15
101-200	6	15	20
Over 200	6	20	25

Centres have three working days to upload the selected learner work. Mark submission guidance is provided in the Portal User Guide to support this activity, and all learner work must be securely retained until final grades are awarded and any queries or appeals are resolved.

If all centre marks are within tolerance of the Moderator review, they will be accepted as final. If any centre marks are outside of tolerance, the moderation moves to stage 2, and the moderation sample is increased. If marking is not consistent, the sample size will be further increased, as illustrated in the sampling size table.

Late submissions

A late submission will only be considered at TQUK's discretion, and extensions are only granted in exceptional cases. Centres anticipating any delays must submit a Special Consideration request. Failure to meet the deadlines may result in delays to results, ineligibility for results day, and a review of the centre's risk rating, potentially leading to compliance investigations.

External moderation process

TQUK will assign Moderators to remotely review selected samples, ensuring that the assessments align with national standards. Moderation outcomes, alongside provisional results, will be accessible to centres via the Portal.

If the centre-assigned marks and moderation outcomes are within an acceptable tolerance range, the centre's marks will be applied.

Where the marks fall outside the tolerance range, a regressed mark may be applied across the learner cohort.

TQUK may request the submission of all learner work for review.

A Final Moderation Report will be provided to centres via the Portal by 14 May and will include confirmation of results, feedback on good practice, a identify any areas of improvement.

The table below outlines the key dates relating to the moderation process.

Moderation Schedule		
Activity	**Deadline date**	**Notes**
NEA brief released	September (annually	NEA briefs are available to approved centres by Verve
Standardisation training window	1 October – 28 February	All assessors must complete standardisation using TQUK materials
Submission of learner marks	30 April	Centres must submit marks via the Portal
Release of moderation sample lists	1 May	TQUK releases a list of learners to be sampled
Upload of selected learner work	Within 3 working days of 1 May	
Resubmission deadline	14 June	

Review of moderation for the NEA

Following completion of a clerical check, the centre may appeal the results of the NEA moderation process. In such cases, TQUK will review the original moderation to ensure that all adjustments were applied fairly, reliably, and consistently.

If a centre has concerns regarding the moderation of a specific cohort, it must request a review of moderation for all learners within that cohort. Written consent from all learners in the cohort is required for the appeal to proceed.

A review of moderation is expected to take 20 working days from when the centre formally instructs TQUK to undertake the review. TQUK will inform the centre if circumstances dictate that this timescale cannot be met.

Full details of the appeals process, including reviews of moderation, can be found in the Appeals Policy on our website.

Section 5: Appendices

Terminology

The following table defines the terminology used in this qualification specification.

Term	Definition
Examination Assessment	An externally set assessment that is internally marked and externally moderated by TQUK
Extended Response Question	An assessment question format that requires a detailed response and is often used to assess a learner's reasoning, analysis, or evaluation skills
External Moderation	The process of reviewing assessment decisions to ensure they meet accepted standards. TQUK will assign a moderator to review samples of learner work
Internal Standardisation	The process of ensuring consistency and fairness in the application of assessment decisions across assessors within a centre
Late Submission	Any submission received after the published deadline will be considered late and will only be marked at TQUK's discretion
Mark Scheme	A structured framework to determine how marks are awarded, outlining expected and acceptable answers, and the grading criteria to support grade application
Multiple Choice Question	An assessment question format where learners select the correct answer from a list of predefined options
NEA Brief	The Non-examination Assessment
Non-examination Assessment	A mode of assessment involving a project and a series of tasks that learners complete in a controlled environment in a timeframe defined by TQUK
Raw Marks	The initial score achieved before any adjustments are applied
Retake	An opportunity for a learner to reflect on their NEA and the internal feedback received, and improve it **before** it has been externally moderated by TQUK.
Resubmission	An opportunity for a learner to revise and submit their work again **after** their original attempt(s) have been externally moderated by TQUK.
Short Answer Question	An assessment question format where a brief, concise response is required and is typically used to assess the recall or understanding of key facts or concepts.
Special Consideration Request	A formal application for reasonable adjustments to be put in place due to unforeseen circumstances that impact a learner's assessment performance.
Uniform Mark Scheme (UMS)	A standardised scoring system that is used to convert raw marks from assessments and is used across different assessment series to support the fair comparison of results.

Verve	TQUK's management system is used by centres for learner registration, the submission of marks, and certification claims. The system is also referred to as the Portal.

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Amplification Terminology

The following table provides a selection of amplification statements used in the Alternative Academic Qualifications. This list is not exhaustive but does provide a range of commonly used statements to provide teaching staff with the intent and scope of the learning objectives.

Common amplification statements	
Characteristics and scope	**Definition**
Aspects of …	The various parts, features, or perspectives of a subject
A range of …	A collection of related items or things
The characteristics/features of …	The unique attributes or qualities of something
Common types of …	The usual classifications found within a subject
The components of …	The individual parts that combine to form a whole
The concepts of …	The ideas that are fundamental to understanding something
The elements of …	The primary components within a specific context
The fundamentals of …	The essential principles for understanding a particular subject
The types of …	The classification of different parts of a subject
The properties of …	The constituent parts or inherent characteristics of something
Function	
The contribution of …	The role something plays in achieving a result
The definition of …	The explanation or meaning of something
The function of …	The specific action or role performed by something
The principles of …	The fundamental concepts or rules underlying something
The purpose of …	The underpinning reason or intent behind something
The role of …	The specific function that something plays in a given context
Implementation	
Approaches for …	Methods or strategies for addressing a problem or achieving an objective
The application of …	The practical use or implementation of an idea or method
Considerations …	The factors to take into account
Controls when …	Measures to guide actions in certain situations
The procedures for …	The established steps for completing a task
Steps to take when …	Specific actions to be taken in a particular sequence
Strategies to …	Plan of action designed to achieve a desired result
Technical considerations …	Specific technical factors to be considered in a particular context
The use of …	The act of utilising something for a particular purpose
The ways in which …	The ways or techniques used to achieve something

Significance	
The benefits of …	The positive effects or advantages of something
The challenges associated with …	The difficulties or obstacles related to a specific topic
The criteria for …	The standards or principles used for judging or deciding something
The cultural considerations of …	Aspects related to the customs, beliefs, and social behaviour of a particular society that affects a subject
The impact / potential impact of …	The effect that something has on another
The importance of …	The significance or value of something
The meaning of …	The explanation or definition of a term or concept
A range of factors to consider when …	The elements that influence the outcome or development of something
Impact	
How X affects Y …	The direct impact one factor has on another
The consequences of …	The results or effects of or influence of an action or decision
The effects of …	The changes that result from an action
The influence of …	The capacity to have an effect on something
The implications of …	The possible future effects of a decision or action
The potential barriers to …	The factors that may hinder progress
The risks of …	The potential negative outcomes of an action
Development	
Methods of …	The ways of doing something
The origin of …	The beginning or source from which something develops
The evolution of …	The gradual change or development of something over time
The stages of …	The distinct phases or periods in a process
The structure of …	The organisation or arrangement of something
Distinctiveness	
The advantages of …	The beneficial aspects of something
The differences between …	The distinguishing characteristics between two or more things
Different ways of …	Various approaches to accomplishing something
The disadvantages of …	The unfavourable or detrimental aspects of something
The diversity of …	The variety or range of differences within a group
The limitations of …	The restricting factors or constraints of something
The positive and negative impact of …	The beneficial and detrimental effects of something
Regulatory	
Legal requirements …	The legal obligations related to something
The minimum requirements …	The lowest acceptable standards or thresholds

The responsibilities of …	The required actions and considerations
The scope of practice …	The boundaries of an individual's competence or responsibilities
Review	
Best practice for …	The most effective method or approach to achieve the desired result
The evaluation of …	The process of assessing the value or significance of something