Chief Examiner and Chief Moderator Report

T Level Technical Qualification in Health
QN: 603/7066/X

Summer 2025 – Occupational Specialism Supporting the Mental Health Team

Introduction

Summer 2025 – Occupational Specialism (OS) Supporting the Mental Health Team

Assessment dates: 10 March 2025 to 13 June 2025

Paper number: P002734, P002738 and P002736

This report contains information in relation to the externally assessed component provided by the Chief Examiner and Chief Moderator, with an emphasis on the standard of student work within this assessment.

The report is written for providers, with the aim of highlighting how students have performed generally, as well as any areas where further development or guidance may be required to support preparation for future opportunities.

Key points:

- grade boundaries
- standard of student work
- evidence creation
- responses to the external assessment tasks
- administering the external assessment.

It is important to note that students should not sit this external assessment until they have received the relevant teaching of the qualification in relation to this component.

Grade boundaries

Grade boundaries for the series are:

	Overall
Max	380
Distinction	275
Merit	186
Pass	97

Grade boundaries are the lowest mark with which a grade is achieved.

For further detail on how raw marks are scaled and the aggregation of the OS element, please refer to the Qualification Specification.

Administering the external assessment

The external assessment is invigilated and must be conducted in line with our Regulations for the Conduct of External Assessment document. Students may require additional pre-release material to complete the tasks. These must be provided to students in line with our regulations.

Students must be given the resources to carry out the tasks and these are highlighted within the Qualification Specific Instructions for Delivery (QSID) document.

Standard of student work

External assessment

Overall, student performance in this series was slightly better than that of the previous series. This improvement appears to be largely due to providers becoming more familiar with the assessment processes and subsequently embedding this understanding into their teaching. As a result, students were better prepared for the demands of the assessment and demonstrated a clearer understanding of both the specification content and how to apply this within the assessment context.

The assessments in this series closely replicated those from previous series, which supported students in developing confidence with the assessment format. Patterns in student performance were consistent across the cohort, particularly in how they demonstrated knowledge and understanding of the specification content and their ability to meet the assessment requirements. Most students attempted all questions, showing good engagement with the paper. However, there were still some instances where responses were crossed out or left incomplete, which limited opportunities to access marks.

A range of achievement was observed across the cohort, reflecting differences in the depth of understanding and the ability to apply knowledge to the given contexts. While higher performing students were able to demonstrate well developed answers with clear links to the assessment criteria (AC), lower performing students often provided more superficial responses, lacking detail or analysis.

For future series, it would be beneficial to remind providers of the importance of ensuring students are confident not only in their subject knowledge but also in how to apply this knowledge effectively within the assessment. Encouraging students to attempt all questions, even if unsure, and to avoid unnecessarily crossing out responses would further support their opportunity to achieve higher marks.

Moderated assessments

Assignment 2 is split into two sections: Supporting Healthcare Assignment 2 Practical Activities – Part 1, followed by Supporting the Mental Health Team Assignment 2. These assessments are internally assessed at provider premises through simulated performance. The provider appoints their own assessors, then external moderation is carried out by NCFE-appointed moderators. Most students were well prepared for the assessments, and in the best evidence providers ensured that all available equipment was available and the standardised patients participating in the simulations were adequately briefed and prepared to play their role consistently.

Supporting Healthcare assignment 2 practical activities – part 1

The 2025 cohort have performed well in assignment 2, and it is evident that many students have benefited from time in industry placement and from simulation opportunities organised by providers. Part 1 and 2 assessment scenarios are unseen by students. They need to attend prepared for anything. The students who scored higher were able to consider the task holistically and demonstrate not only the scenario-specific skills required in each task, but then also interweave the appropriate underpinning skills required to be able to complete the scenario successfully to a high quality.

Students who scored lower lacked consistency within their practice and did not always fully complete all parts of each scenario. Often, communication skills with the patient or others involved and poor or incomplete written documentation were factors impacting on the awarding of higher marks.

In a minority of cases standardised patients or assessors were not fully compliant with the provider brief. This occasionally restricted the opportunity for students to interact and demonstrate both scenario-specific skills and the underpinning skills relevant to patient-centred care.

Supporting the Mental Health Team assignment 2 – practical activities part 2

Overall, students engaged positively with the four practical scenarios and demonstrated appropriate tone and empathy. Most were able to build basic rapport, but the depth and accuracy of responses varied. Common strengths included calm communication and willingness to support individuals. However, recurring issues were limited personalisation of plans and strategies, incomplete or superficial documentation and difficulty distinguishing between thoughts, feelings, behaviours and physical sensations. There were missed safety considerations in risk-sensitive scenarios. Further focus on reflective practice, accurate recording, and person-centred planning would strengthen performance across future series.

Evidence creation

External assessment

Within the OS, a range of evidence was produced by students, including digital recordings, Microsoft Word documents, and completed proformas. While the majority of students submitted evidence in the expected formats, there are still ongoing issues that have been highlighted in previous Chief Examiner reports. Notably, some students continue to recreate the proformas provided by NCFE, despite these being readily available in both Word and PDF formats. This practice not only results in unnecessary use of valuable assessment time but also frequently leads to students missing out key questions or sections, ultimately impacting their performance. Students who utilised the NCFE-provided documents were generally more successful, as they were able to focus their efforts on demonstrating their knowledge and skills rather than replicating documentation.

The quality of digital recordings showed improvement compared to previous series. Many providers have clearly taken on board previous feedback, with a significant number now using microphones to enhance the clarity of recordings. This ensured that the student's responses were captured clearly and could be accurately assessed. However, there were still some instances where the quality of recordings was compromised. In particular, background noise – such as conversations from outside the room or cleaning staff using vacuum cleaners – was evident in some submissions. This not only risked distracting the student during their assessment, but also made it more challenging for assessors to fully interpret the responses.

Overall, while there have been clear improvements in the quality and range of evidence provided, providers should continue to reinforce the importance of using the official proformas and ensuring that recording environments are free from unnecessary background noise to support students in achieving their full potential.

Moderated assessments

Supporting Healthcare assignment 2 practical activities – part 1

Assignment 2 relies on the evidence uploaded by each provider. It is essential that complete evidence for both parts 1 and 2 is uploaded to the evidence portal. Providers must also ensure all evidence for each student is retained as per the Provider Guide instructions. In some cases, it may be appropriate to extend sampling and if this is the case moderators must be able to see all the evidence requested. The evidence checklists have been used and uploaded as required by some providers this year, but not by all. These are important to help identify any issues with evidence; for example, if a recording had to be stopped and restarted due to a camera malfunction, or if some evidence has been corrupted.

There was a lot more missing evidence this year which led to delays with the moderation process whilst we had to wait for action from providers. The checklists should be used by all providers and uploaded

with evidence. Evidence consists of the student assignment brief and evidence booklet, complete video recordings of all scenarios, an assessor narrative on the observation and justification for marks awarded and the marks completed for scenario-specific skills and underpinning skills.

Page 4 of the assignment brief has a student submission form to complete, and this was left blank by some students. Please advise students in future that this page must be completed and signed as part of their evidence submission.

It is important to remind students that they should present themselves as if they were working in the care setting; we saw a range of clothing that would be inappropriate to wear if working in health care. They should be bare below the elbows and jewellery such as bracelets should be removed. Also, it is advised that long false nails are not worn as they constitute an infection risk and would not be allowed in clinical care. Hair should also be tied up.

Across the range of evidence, varying quality was seen. In the most comprehensive examples, all evidence was uploaded as required and each piece was labelled clearly; assignment brief evidence booklets were completed, scanned and uploaded. Video best practice included for each scenario: a complete recording with an introduction naming the student and provider; the five minutes reading time; the actual task simulation including handwashing, donning and doffing Personal Protective Equipment (PPE); communicating results and explaining them to the patient, depending on the task; notes completion; and finally the assessor asking the student ‘can you confirm you have finished this task?’. The better assessor narratives were comprehensive and matched closely what could be seen in the video recordings.

Templates for the assessor observation of skills recording forms were provided and in most cases were used well. A minority of providers had attempted to replicate the awarding criteria within their narrative, which is not what is asked for within the provider guide. The use of some of the descriptors, such as basic, good and outstanding, does help the moderator understand where your marks have come from. The detail recreates the assessment, including specific examples of performance that will support the assessment decision or justify the outcome.

Less robust evidence included partial or missing recordings. It is not sufficient for students to announce they have previously washed their hands for a task where handwashing equipment has been supplied, we expect to see them doing this thoroughly and then use PPE if it is in the equipment list. Some recordings were obscured by the positioning of the camera; the student might have their back to it or be completing some of the tasks outside of the camera angle. The audio quality should be checked beforehand to ensure other assessments going on in nearby areas are not compromising the quality of the recording.

Written evidence required in the scenarios differs depending on the task. In general, this was an area where many students could have performed better, ensuring all areas requiring completion were completed to the standard that would be expected of them at this level in industry. Depending on the scenario it should be an accurate reflection of what care has been provided, what observations have been made, any deviations from the normal and appropriate actions taken. These documents should be of use to the ongoing care team.

Supporting the Mental Health Team assignment 2 – practical activities part 2

Written entries in the communication assessment document varied in quality. Most students used appropriate language, but many responses lacked depth. Grammar and spelling were generally acceptable, though some responses included unclear phrasing or overly informal tone. Students who demonstrated stronger written communication generally produced clearer, more professional care plans with appropriate vocabulary.

To support improved student outcomes in future series, providers are advised to improve recording skills and practice structured documentation of observations using templates or tools like communication assessment forms, with a focus on clarity and relevance.

The session record form (Item D) was often incomplete, too brief, or lacking rationale. Many students listed strategies without explaining how or why they would support, missing opportunities to link suggestions to experiences.

Responses to the external assessment tasks

Assignment 1 – case study
Task 1: assessment of the patient and situation

For task 1 in assignment 1, students were required to review the assessment notes from the Community Mental Health Team (CMHT) and complete the Situation, Background, Assessment, Recommendation (SBAR tool) to communicate information to the mental health team caring for Molly. Overall, students performed particularly well on this task. This strong performance appears to be linked to the clear structure provided by the SBAR tool and the familiarity students now have with this format, which has been consistently referenced in previous guidance. The SBAR framework gave students a clear step-by-step process to follow, supporting them in organising their responses effectively.

Generally, students demonstrated a good understanding of how to state the situation clearly and provide relevant background information. Most were able to extract key facts from the CMHT assessment and use these appropriately in their responses. However, there were some common issues observed. A minority of students included irrelevant details or copied sections of the notes verbatim without interpreting or summarising the information, which limited their ability to show deeper understanding.

The assessment and recommendation sections were where differences in performance were most evident. Higher achieving students went beyond simply restating information and provided thoughtful assessments based on the facts, linking these to Molly's current needs. They also made clear, actionable recommendations that were appropriate for the mental health team. In contrast, weaker responses tended to list actions without clear justification, or recommendations were vague and lacked a clear rationale.

Overall, this task was well answered, with students benefiting from the structured nature of the SBAR tool. Providers should continue to emphasise the importance of not only completing each section but also demonstrating interpretation, analysis and clear reasoning – particularly within the assessment and recommendation components – to secure higher marks.

Task 2: goals, patient outcomes and planned outcomes

For Task 2, students were required to read the notes from the meeting with Molly's mum and use this information to recommend short-term and long-term goals for Molly's care, along with the actions required to achieve these goals and consideration of potential barriers. Overall, students performed well across the cohort, with many providing clear and relevant goals for Molly that reflected the information provided in the scenario. This indicates that students were generally confident in extracting and applying key details from the case notes to inform their responses.

Most students successfully identified goals that were appropriate to Molly's needs and aligned with the care planning process. However, there was some confusion among a number of students regarding the distinction between short-term and long-term goals. In some cases, goals were too broad or vague, while in others, short-term goals were more accurately described as long-term, and vice versa. This limited the clarity and accuracy of their responses and, in turn, the marks they could achieve.

Stronger responses were characterised by well-defined goals, supported by specific and realistic actions that linked directly to Molly's current situation and future needs. These students were also able to clearly identify potential barriers to achieving the goals and provided thoughtful strategies to address these. A particular strength in higher scoring responses was the consideration of how the Multi-Disciplinary Team (MDT) could support Molly in both achieving her goals and overcoming identified barriers. These students demonstrated a strong understanding of the collaborative nature of care planning and the roles of different professionals involved in Molly's care.

Providers should continue to emphasise the importance of distinguishing between short- and long-term goals and encourage students to make explicit links to the MDT when discussing actions and barriers. Developing this understanding further will help students to produce more detailed and analytically strong responses in future assessments.

Task 3: care, treatment and support plan

For task 3, students were required to write a treatment report discussing the strengths and limitations of medication and Cognitive Behavioural Therapy (CBT), as well as making recommendations for further interventions or treatments for Molly. Overall, the cohort performed well on this task, with clear evidence that many students had developed a fantastic understanding of the treatments involved. Most students were able to discuss both the benefits and drawbacks of medication and CBT, drawing on the information provided and their own knowledge of mental health treatment options.

Stronger responses were characterised by well-balanced discussions that not only identified strengths and limitations but also evaluated these in detail. These students demonstrated higher level thinking by considering factors such as cost, treatment times, availability of service and location, as well as how these factors might impact Molly's treatment outcomes. They also provided well-justified recommendations for further interventions, often suggesting additional support options such as family therapy, support groups, or ongoing community-based care.

However, there were differences in the depth of evaluation across the cohort. While most students could describe the strengths and limitations, some responses were more descriptive than analytical. These weaker answers tended to simply list benefits and drawbacks without linking them to Molly's situation or without considering the broader implications of factors like accessibility or long-term effectiveness. Additionally, a small number of students missed opportunities to provide detailed recommendations, limiting the marks they could achieve.

Providers are encouraged to continue supporting students in developing evaluative skills, ensuring they can go beyond description to critically consider how different factors influence the effectiveness and suitability of treatments. Reinforcing the need to relate these evaluations directly to the case study will also strengthen future responses.

Task 4: evaluation, monitoring effectiveness and clinical effectiveness

For task 4, students were asked to write a relapse plan to support Molly upon her discharge from hospital, requiring them to evaluate her progress, identify early warning signs or triggers for relapse and outline coping mechanisms or strategies to recommend. This task proved to be the weakest of the four in terms of student performance.

A noticeable factor contributing to lower achievement was evidence that some students had run out of time, suggesting that time management across the assessment could be improved. There were also signs of exam fatigue, as seen in responses where students resorted to bullet-pointing key points rather than fully evaluating Molly's progress. These incomplete or underdeveloped responses limited the marks available to those students.

In terms of content, there was a clear distinction between stronger and weaker responses. Students who demonstrated a good understanding of the purpose of a relapse plan were able to provide well-structured evaluations of Molly's progress, identifying both positive aspects and areas of concern. These students also effectively contextualised their recommendations, ensuring they were realistic and relevant to Molly's situation. They considered her expressed concerns, such as stigma and the need for more CBT sessions, and suggested appropriate coping strategies and MDT support.

Conversely, weaker responses were often vague, lacking depth and critical evaluation. Some students listed potential coping strategies without linking them to Molly's specific circumstances, while others made recommendations that were unrealistic or not supported by the case study. Additionally, a few responses failed to identify early warning signs or triggers effectively, limiting the overall quality of their relapse plans.

Providers should reinforce the importance of time management during assessments and encourage students to practise planning their responses to ensure they can fully address all aspects of the task. Additionally, focusing on the purpose and application of relapse plans and how these should be tailored to individual case studies, will help students strengthen their responses in future series.

Assignment 1: overall

Student performance in this series showed a slight improvement compared to previous ones, largely due to providers' growing familiarity with the assessment process and teaching accordingly. The tasks mirrored previous assessments, allowing students to demonstrate consistent knowledge and understanding.

Task 1 was the strongest, with most students confidently using the SBAR tool. Task 2 was also well completed, though some confused short and long-term goals or failed to fully consider the MDT. In task 3, many students effectively evaluated treatment options, with stronger responses considering wider factors such as accessibility and outcomes. Task 4 was the weakest, with evidence of exam fatigue and poor time management, resulting in vague or unrealistic recommendations.

English, mathematics and digital skills were generally strong, but some students recreated proformas instead of using those provided, leading to omissions. Mathematical skills were only relevant in setting timeframes, where some responses were more realistic than others.

Providers should continue to support students in:

- managing time effectively to complete all tasks
- producing evaluative rather than descriptive responses
- correctly using supplied digital documents
- making realistic, contextualised recommendations.

For assignment 1, there was variation in the demonstration of English, mathematics and digital skills across the cohort. Some students displayed strong English skills, producing well-structured responses with clear, concise language and appropriate use of terminology. These students were able to communicate their ideas effectively, which enhanced the overall quality of their work. However, others demonstrated weaker written communication, with occasional issues in spelling, grammar and sentence construction, which sometimes detracted from the clarity of their responses.

In terms of digital skills, the majority of students were able to navigate and use the required digital formats effectively. However, there were still instances where some students recreated the proformas rather than using those provided, which not only wasted valuable assessment time but also resulted in missing elements of the tasks. This reflects the need for providers to reinforce the importance of using the resources supplied to ensure full completion of requirements.

Mathematical skills were not directly necessary during this assessment; however, in task 2, where students were required to set short- and long-term goals for Molly, some demonstrated a better understanding of realistic timescales than others. Stronger responses presented timeframes that were appropriate and achievable in relation to the context of Molly's situation, while weaker responses included timescales that were either too vague or impractical, impacting the credibility of their care planning.

Providers should continue to support students in refining their written communication and digital literacy skills to ensure they can present their ideas effectively within the assessment framework. Additionally, encouraging students to consider the realism and appropriateness of any time-related recommendations will further strengthen their responses.

Overall, the cohort demonstrated progress, with many students showing improved application of knowledge to the case study.

Assignment 2 practical activities Part 1 - Supporting Healthcare (Core)

Scenario 1: This task required the student to take the physiological measurements of a 58-year-old man attending for a 6 monthly diabetes check-up. They then had to record the consultation on the GP referral notes and report any concerns. The students were directed to measure weight, heart rate and blood pressure. Handwashing facilities and PPE were also expected to be used as they were on the equipment list for the scenario in the provider guide. Students who performed well demonstrated understanding of the need for infection prevention and control measures, washed their hands demonstrating an approved technique and donned and doffed PPE appropriately.

In general, students managed the taking of the physiological measurements well, demonstrating the appropriate technique and using equipment correctly. The higher marked students showed best practice by measuring the heart rate for a full 60 seconds and asking the individual to step on the scales twice rather than once. There were still some students who did not position the BP cuff correctly or talked to the individual whilst measuring their BP, which could have impacted the accuracy of the measurement. Providers provided the results of the scenario measurements in several ways. It is best practice to tell the student each measurement when they have finished the demonstration of each technique. It is not advisable to interrupt the student whilst they are measuring the heart rate and tell them the measurement to use, as it often interrupted their demonstration and it was therefore not evident if they would have continued for the full 60 seconds.

The record keeping did not always capture any recognition of the changes in the measurements from the previous visit, this is where the concerns should have been apparent. This connection was often missed by the lower marked students who failed to mention the trends and why they were concerning or make any links to the individual's health condition – diabetes.

Scenario 2: This was a moving and handling task where the student was working in a residential care home and had to carry out a risk assessment on the moving and handling of an elderly individual from a wheelchair to a chair. They then had to follow their own risk assessment and work with a second member of staff to move the individual safely. Following the transfer, they had to review their risk assessment form and make any amendments as necessary.

This task was challenging for some students. Lower marked students sometimes carried out the transfer before making their risk assessments so had not read and followed the brief carefully. The opportunity to reflect on the risk assessment and make amendments was then compromised, resulting in an incomplete task. Some carried out the transfer alone, so had not used the information clearly given within the brief that the individual required 2 people and a transfer belt to move safely. Their written documentation was poorly completed with a lack of detail.

The higher marked students followed the brief carefully and completed a detailed risk assessment usually involving the individual for their input, which would be best practice. They prepared themselves and their equipment, used the handwashing facilities and PPE appropriately and had a sound, safe working knowledge of how to use the handling belt correctly. They engaged with the second member of staff and directed them clearly in what they wanted them to do to support the transfer. Their risk assessments had detailed and clear instructions for other staff to use when supporting this individual in the future.

Scenario 3: This task required the student to respond to a patient fall in hospital and deal with a blood spillage. The patient is confused**,** agitated and being verbally aggressive to the staff. They are found on the floor with an arm injury, bleeding. This task did prove to be quite challenging for several students but for a variety of different reasons. Provider compliance in some instances impacted the students' ability to demonstrate the clinical skills, knowledge and understanding. It is important that standardised patients and other staff members are prepared thoroughly and follow the provider guide instructions carefully. This then ensures that the approach between students and across providers is consistent and does not limit or impact student opportunity. Examples of this included the additional staff member not using the script and asking the student to apply first aid and move the patient back to bed before cleaning the blood spillage. First aid was not part of this assessment; there were no resources to be provided in the equipment list for this to be carried out and the additional member of staff should have taken control of the patient once they arrived on scene and instructed the student to clean the spillage.

A full blood spillages kit should be provided as per the equipment list, these usually contain items such as PPE, granules to solidify the spillage, a scoop and scraper, waste disposal bag and cleaning solution. In some cases, only blue roll and spray was provided, which again limits the student's ability to demonstrate the use of a spillage kit. Moderators were instructed to award positively if the student used what they had been provided with in the best way they could, but again it demonstrates how it is important to ensure that the provider guide instructions and provision of the correct equipment are crucial for the success of your students.

The higher marked students in this task performed excellent infection prevention and control measures, washing their hands and donning and doffing PPE correctly. They demonstrated excellent duty of care, placing the patient first. They summoned help immediately on finding the patient and did not wait until they had washed their hands and applied their PPE, which would delay first aid assessment and treatment. They tried to remain calm and reassure the patient using their communication skills well whilst waiting for the nurse to arrive. Once the nurse arrived, they then moved as instructed on to the cleaning up of the spillage and used each component of the spillages kit correctly. Documentation was detailed and clearly stated events and who did what.

Students who marked lower often did not summon help until after they had washed their hands and applied their PPE. They did not engage well with the patient or attempt to calm and reassure them, sometimes ignoring their repeated calls for help whilst washing their hands. There was a minority who assisted the patient back to bed themselves without the appropriate risk assessment being done by the nurse, overstepping the limitations of their role and a potential safeguarding issue. The use of the spillages kit was less confident and infection prevention and control measures were often inconsistent.

Assignment 2 practical activities
Part 2 - Supporting the Mental Health Team

Part 2b: Observed practical tasks: this section of the practical activities assignment required students to complete a series of four observed tasks in a controlled environment, simulating real-world mental health support scenarios. The tasks assessed students' ability to apply theoretical knowledge in practice, demonstrate safe and effective communication and work within the scope of their role to promote the wellbeing, dignity and independence of individuals experiencing mental health challenges. Each task

was designed to reflect realistic therapeutic settings, allowing students to showcase their practical competence and professional judgement in line with the occupational specialism requirements.

Scenario 1: Observing and assessing communication in an individual with dementia

This practical activity required students to complete an observational assessment of Alix, a 50-year-old individual who had been diagnosed with dementia 10 months prior. The task took place in a clinic setting without Alix's son present. Over the previous month, Alix's condition had deteriorated, with increasing forgetfulness, reduced communication and difficulties in word-finding. Students were asked to undertake a conversation with Alix to observe his verbal and non-verbal communication, and to record their findings in a communication assessment document (Item A). Assessment also considered how well students demonstrated person-centred approaches, communication and relationship skills and awareness of safety and service frameworks.

Students generally engaged positively with scenario 1 and were able to observe and record at least some elements of Alix's communication. Many demonstrated basic understanding of the symptoms associated with dementia and made references to observed behaviours such as reduced speech, hesitations and signs of confusion or anxiety. Stronger students identified key verbal signs, such as word-finding difficulties, repetition or limited vocabulary. They noted non-verbal behaviours, such as facial expressions, body posture, eye contact or fidgeting. They were able to describe how these observations might relate to Alix's condition and communicated them clearly in the written assessment, demonstrating empathy and patience and adjusting their own communication appropriately. However, weaker responses tended to focus more on completing the conversation rather than actively observing or reflecting on communication. In some cases, students recorded vague or generic statements for example 'he seemed confused without supporting detail'. A number of students did not clearly distinguish between verbal and non-verbal communication or failed to link their observations to potential symptoms or support needs.

Very few students considered the environmental or safety factors related to supporting an individual with dementia. While the setting was a clinic, it was expected that students would take into account potential disorientation or anxiety Alix might experience without his son present. Commonly missed considerations included making the environment more comfortable or dementia-friendly, offering reassurance and orienting Alix to time, place or purpose, recognising the importance of emotional safety and reducing potential distress and awareness of how their own body language or positioning might support or inhibit communication. Students who did acknowledge these factors typically performed at a higher level and demonstrated a more holistic approach.

Written entries in the communication assessment document varied in quality. Most students used appropriate language, but many responses lacked depth or structure. Grammar and spelling were generally acceptable, though some responses included unclear phrasing or overly informal tone. Stronger students used observational language confidently and concisely, with clear separation of verbal and non-verbal indicators, whilst weaker entries were often too brief, used vague descriptions or relied heavily on subjective language such as 'seemed fine' or 'looked okay' without specific examples.

To support improved student outcomes in future series, providers are advised to emphasise the difference between verbal and non-verbal communication by providing teaching and exemplar materials that help students identify and document both forms clearly and confidently. To develop observational skills, use structured observation exercises, role plays or video analysis to train students to pick up on subtle communication cues. Link observations to clinical relevance, supporting students in understanding how dementia symptoms manifest in communication and how these may inform future care or support plans. Encourage dementia-sensitive approaches, reinforce the importance of creating a calm, respectful environment and using supportive communication strategies with individuals experiencing cognitive decline and improve recording skills by practicing structured documentation of observations using templates or tools like communication assessment forms, with a focus on clarity and

relevance. With greater focus on accurate observation, contextual awareness and person-centred recording, students will be better equipped to support individuals with dementia in clinical and community settings.

Scenario 2: Supporting an individual with anger management difficulties

In this practical activity, students participated in a one-to-one session with George, a 42-year-old man attending a mental health outpatient clinic following a traumatic car accident. George reported difficulties with anger management, which were negatively affecting his daily life and relationships. The purpose of the task was to enable students to discuss George's emotional and physical symptoms and offer information on strategies to support his mental health. Students were also expected to complete the associated personal management plan (Item B) and demonstrate underpinning skills including communication, person-centred care, health and safety awareness and understanding of relevant service frameworks.

Overall, students engaged well with the scenario and demonstrated a reasonable understanding of how to support an individual experiencing emotional dysregulation. Many students approached George with empathy and maintained a calm, non-judgemental tone throughout the discussion. Open-ended questioning, active listening and simple de-escalation techniques were commonly observed among stronger students. Higher performing students were able to explore George's emotional and physical symptoms appropriately and explain practical anger management strategies such as breathing techniques, journaling or referral to psychological support. They demonstrated confidence, professionalism and self-awareness during the interaction, accurately and clearly completing the personal management plan with relevant and achievable actions.

However, weaker responses tended to be reactive rather than proactive. Some students provided general reassurance or vague advice without first gathering sufficient information. Others focused solely on anger, without acknowledging underlying emotional triggers or trauma. In some cases, the discussion lacked structure, and the written management plan was incomplete or too generic to reflect person-centred care.

A notable omission across the majority of the cohort was the failure to consider personal safety and risk management prior to the appointment. Although George had disclosed a tendency to lash out and hit objects, very few students demonstrated awareness of how this should influence the setup of the environment or planning of the session. Overlooked risk considerations included, informing colleagues of their location and expected duration of the appointment, ensuring awareness of how to raise the alarm or summon assistance, positioning themselves close to the exit or using a desk as a physical barrier and removing potential triggers or ensuring the space was safe and neutral. This highlights the need for greater emphasis on environmental risk assessment as part of safe and effective mental health support.

Most students used appropriate tone and language when engaging with George, maintaining a supportive and respectful manner. However, a minority used informal or inappropriate terminology such as 'chill out' or 'do not get angry'. Written documentation in Item B ranged from well-structured to poorly organised, with some spelling and grammar issues that affected clarity. Students who demonstrated stronger written communication generally produced clearer, more professional care plans with appropriate vocabulary.

To support stronger student outcomes in future series, providers are encouraged to embed risk awareness in all practical scenarios, ensuring students are taught to assess the safety of the environment and make reasonable adjustments in line with risk and organisational policies. Teach communication frameworks to support students in structuring support conversations such as using 'acknowledge, explore and respond' models to avoid superficial or unbalanced dialogue. Look to expand strategy knowledge, reinforce a range of evidence-based techniques that students can draw on during mental health discussions. Link theory to practice by integrating trauma-informed care and emotional

regulation theory into practical teaching and strengthen written communication using formative activities to practise writing clear, person-centred management plans using appropriate language and structure. With greater emphasis on preparation, professional communication and dynamic risk assessment, students will be better prepared to manage emotionally charged interactions in a safe and supportive manner.

Scenario 3: Supporting an individual in recovery – relapse prevention planning with Mo

In this practical activity, students engaged in a one-to-one discussion with Mo, a 48-year-old man in recovery from alcohol addiction. Mo had been abstinent for just over five months and expressed pride in his progress, but concern about possible relapse due to social and emotional triggers. The task took place in a community rehabilitation setting and required students to discuss relapse prevention strategies and complete a **r**elapse prevention plan. The scenario also assessed students' ability to demonstrate person-centred communication, emotional sensitivity and awareness of support frameworks to promote mental and physical wellbeing.

Most students engaged with the scenario in a calm and supportive manner, and many demonstrated empathy toward Mo's achievements and concerns. Students who performed well structured their discussions logically, starting with general wellbeing before exploring relapse risks and available support.

High performing students asked relevant, open-ended questions that allowed Mo to disclose key triggers, goals and concerns. They responded to emotional disclosures with reassurance and sensitivity, such as his grandmother's death, stress at work or social isolation and provided appropriate information about relapse prevention strategies such as avoiding high-risk environments, using distraction techniques, mindfulness, journaling or accessing peer support. They clearly explained the role of other professionals and where Mo could seek further help such as keyworkers, mental health practitioners and community services.

However, a number of students missed opportunities to fully engage with Mo to identify his personal triggers. In some cases, the conversation remained superficial or overly focused on general lifestyle advice. As a result, the relapse prevention plans were often generic and lacked the individualised strategies necessary for meaningful support.

A common weakness was the use of vague or unrealistic goals that did not follow the Specific, Measurable, Achievable, Relevant, Time-bound framework (SMART). Examples included goals such as 'do not relapse' or 'be more positive', which lacked structure and clarity. Students who did not guide Mo through the planning process often submitted incomplete or unfocused documentation that did not reflect Mo's personal experiences or context.

To improve performance and confidence in future series, providers should consider teaching motivational interviewing techniques to help students develop strategies for drawing out deeper responses, exploring ambivalence and supporting change. Reinforce SMART goal setting, ensuring students understand how to develop realistic and specific goals in collaboration with the individual, and how this can support self-efficacy and long-term recovery. Use case-based documentation practice, provide regular opportunities for students to complete relapse prevention plans or equivalent documentation based on realistic, complex scenarios. Encourage person-centred engagement, emphasising the importance of fully exploring an individual's background, triggers and support network before suggesting strategies. Build knowledge of relapse prevention models, introducing students to common relapse triggers, prevention frameworks, and multi-disciplinary approaches to support sustained recovery. Promote professional language and tone to support students in using respectful, appropriate terminology when discussing addiction, relapse and mental health. By focusing on structured, collaborative planning and deepening their engagement with individual experiences, students will be better prepared to support recovery and promote mental wellbeing.

Scenario 4: Promoting mental wellbeing – coping strategies session with Sofia

This practical activity required students to conduct a one-to-one support session with Sofia, a 17-year-old student recently diagnosed with an anxiety disorder. Sofia presented with a range of stressors, including parental separation, friendship difficulties and academic pressure. Students were expected to explore Sofia's thoughts, feelings, behaviours and physical sensations linked to anxiety, and recommend three coping strategies or skills appropriate to her needs. After the session, students were required to document the discussion using the session record form. The task also assessed underpinning skills, including person-centred care, communication, holistic working and risk awareness.

Students approached this task with sensitivity, and most engaged Sofia in a calm and supportive manner. Many were able to identify that she was feeling overwhelmed and anxious, and some explored the emotional impact of her home life and academic stress. Stronger students used clear, non-judgemental questioning to explore Sofia's experiences and encouraged her to discuss how anxiety affected her daily routine, social interactions and physical symptoms. They suggested coping strategies that were age-appropriate, accessible and tailored to Sofia's situation such as breathing techniques, journaling, grounding exercises, limiting revision hours or speaking to a trusted adult. They took time to build rapport and emotional trust, demonstrating patience and emotional safety.

However, a number of students failed to fully individualise the support offered. In some cases, they did not spend enough time getting to know Sofia or responding to her disclosures, which limited their ability to recommend strategies that were meaningful or achievable. As a result, many plans included generic or mismatched strategies not clearly linked to Sofia's needs or context.

A frequent issue across the cohort was difficulty distinguishing between thoughts, feelings, behaviours and physical sensations. Some students incorrectly categorised examples or overlooked entire sections of the session record form. This impacted the accuracy of the completed document and showed a limited understanding of the cognitive behavioural model.

The session record form (Item D) was often incomplete, too brief or lacking rationale. Many students listed strategies without explaining how or why they would support Sofia, missing opportunities to link suggestions to her lived experiences.

Most students maintained appropriate professional conduct during the role play. While the scenario did not present immediate risk, students were expected to demonstrate emotional safeguarding by recognising signs of distress and offering reassurance. A few students appeared hesitant to explore sensitive topics such as family separation or social exclusion and would benefit from more guided practice in managing emotionally complex discussions with young people.

Verbal communication was generally appropriate, with students using a calm tone and age-appropriate language. However, some students relied on closed questions or moved too quickly to solutions, several lacked confidence when explaining strategies and some gave overly brief or unclear instructions. Written entries were often too short or incorrectly categorised such as putting 'shaking' under 'feelings' or 'hopelessness' under 'behaviours'. Spelling and grammar were acceptable, but some used informal language that reduced professionalism such as 'you'll be fine' or 'just ignore them'.

To improve student performance in future series, providers are encouraged to focus on strengthening the therapeutic conversation process, reinforcing the importance of building emotional trust and gathering personalised information before offering advice. Clarify the four CBT-based domains using practical classroom tools to teach the differences between thoughts, feelings, behaviours and physical sensations, supported by case examples. Model individualised planning to help students learn how to link coping strategies directly to the individual's stated experiences, rather than relying on pre-prepared or general suggestions. Encourage appropriate questioning techniques, use role play and guided feedback to develop open questioning, active listening and gentle exploration of sensitive topics. To

support confident explanation of strategies, teach students to clearly describe how a technique works and when it might be helpful. To improve documentation skills, use structured templates and peer review to improve clarity, depth and accuracy in session recording. By combining communication, theory and a personalised approach, students can improve the quality of their sessions and better support individuals experiencing anxiety and emotional distress.

Assignment 3
Theme 1: health and safety in mental health settings

Question 1

For question 1, student performance across the cohort was generally positive. Most students effectively drew on their work placement experiences, classroom learning and previous assessments or role plays to explain why following service frameworks and local policies is essential for ensuring the health and safety of individuals with mental health conditions.

The strongest responses came from students who explicitly referenced relevant health and safety legislation and clearly demonstrated how these laws inform policies and procedures in practice. These students were able to provide well-contextualised examples that showcased both understanding and application. To strengthen future performance, providers should continue to encourage students to make explicit links between their experiences, legislation and its practical implications.

Some students struggled to fully interpret the wording of the question, resulting in responses that lacked a clear focus on service frameworks or failed to connect to legislation. Supporting students in breaking down and analysing question wording during preparation could help ensure they address all required elements.

While performance was strong overall, initial answers often reflected assessment nerves, with many students gaining confidence and structure as they progressed into subsequent questions. Incorporating mock professional discussions into teaching could help students build confidence earlier, leading to stronger initial responses.

Question 2

For question 2, student responses varied across the cohort. In part A, most students were able to identify a range of risk factors that could impact health and safety in mental health settings. However, many responses were superficial, listing risks without providing sufficient detail or demonstrating a deeper understanding of how these factors specifically influence practice. Encouraging students to move beyond identification and to explain the implications of each risk would strengthen their answers.

Part B proved to be more challenging. While some students were able to discuss strategies for implementing risk prevention and reduction effectively, many struggled to go beyond general statements. Stronger responses included specific, contextualised examples that showed how risk management strategies are applied in real care settings. Weaker responses lacked depth and failed to link strategies back to the care of individuals with mental health conditions.

To improve future performance, providers should ensure students are confident in not only recognising risks, but also in articulating how preventative measures are implemented in practice. Embedding case studies, scenario-based activities and role plays into teaching could help students apply their knowledge more effectively and respond to this type of question with greater depth.

Theme 2: supporting individuals with mental health conditions
Question 3

Question 3 was the strongest performing area across the cohort. Many students were able to draw effectively on their work placement experiences and previous assessments, including the assignment 2 specialism-based role play activities, to provide detailed and relevant responses.

In part A, students performed particularly well. They were able to identify different types of communication – such as verbal, non-verbal and written – and discuss their importance in supporting individuals with mental health conditions. Responses often demonstrated a clear understanding of how effective communication within a team contributes to co-ordinated care and improved outcomes for service users.

Part B, which required students to evaluate the impact of a mental health support worker's communication skills during the treatment process, was more challenging. While many students provided good examples, some struggled with the evaluation element, tending to describe rather than critically assess the impact. Those who linked their responses to reflective cycle theories, such as Gibbs or Kolb, performed better, as these frameworks helped structure their evaluation and deepen their analysis.

Providers may wish to continue encouraging the use of reflective models and integrating theory into practice-based discussions. This approach supports students in moving from description to evaluation, ensuring they can demonstrate higher level thinking in similar assessment tasks.

Question 4

Student performance for question 4 varied significantly across the cohort. While a small number of students demonstrated an excellent understanding of safeguarding legislation and its application in mental health settings, many struggled to identify and reference specific legislation. This lack of specificity in part A hindered their ability to fully explain the importance of adhering to safeguarding laws when supporting individuals with mental health conditions. Responses were often generalised, focusing on the concept of safeguarding rather than directly linking it to legislative frameworks such as the Care Act 2014 or the Children Act 1989.

Part B was generally approached with more confidence. Students were able to describe the importance of teamwork when safeguarding individuals and often supported their responses with examples drawn from high-profile media cases and case reviews, including Baby P and Victoria Climbié. These references helped contextualise their answers and demonstrated an awareness of the consequences of poor safeguarding practices.

For providers, this highlights the need to strengthen students' knowledge of key safeguarding legislation and ensure they can confidently apply these to case studies and professional scenarios. Embedding more targeted teaching on legislation, alongside opportunities to practice linking theory to practice, would better prepare students to provide detailed and accurate responses in future assessments.

Theme 3: recording, reporting and sharing of information
Question 5

Performance for question 5 was mixed across the cohort. Some students provided clear, well-structured explanations of the different ways of reporting and recording information in mental health settings, successfully linking their answers to examples from placement experiences or classroom learning. These students were able to describe various reporting methods, such as incident forms, electronic care

records and verbal handovers, and explained their relevance to maintaining accurate and confidential records.

However, many responses were vague and lacked the depth required to progress beyond band 1 on the grade descriptors. In particular, weaker answers tended to list reporting methods without explaining their purpose or importance, and part B responses often failed to provide a detailed scenario to illustrate when observation, recording and reporting would be expected.

There were excellent examples where providers had clearly used the questions outlined in the provider guidance to help students extend their answers, which often made the difference between achieving a pass and receiving an unclassified mark. This demonstrates the positive impact of providers who are confident in utilising the guidance effectively within the assessment rules.

It should be noted, however, that in some cases, providers breached assessment regulations by asking additional probing questions outside of the permitted guidelines. These instances were flagged under malpractice procedures by the examining team to ensure fairness and consistency across all student assessments. Providers must remain vigilant in adhering strictly to the set guidance to maintain the integrity of the assessment process.

Question 6

Student performance for question 6 was mixed, with a clear difference in how students approached part A and part B.

In art A, most students could correctly name physiological measurements – such as blood pressure, temperature, respiration rate – and some referenced the NEWS2 score chart. However, many struggled to contextualise these measurements within a mental health care scenario. This gap likely stems from students' limited exposure to mental health settings due to age restrictions and placement opportunities, despite having practiced physiological measurements during their core practical exam. As a result, explanations often lacked the depth required to demonstrate full understanding of why accurate recording is particularly important in the context of mental health care and support.

In part B, responses were generally stronger. Students were able to articulate the importance of team briefings and debriefings for sharing information, improving continuity of care and ensuring patient safety. Many drew on examples from previous placements or classroom learning to support their answers. However, some responses remained superficial, offering general statements without deeper evaluation of how these practices influence outcomes in mental health settings. These lacked the detail needed to achieve marks in the higher bands.

Providers may wish to focus on helping students strengthen their ability to apply theoretical knowledge to mental health-specific scenarios, particularly where direct practical experience is limited. Additionally, encouraging students to expand on the impact and significance of practices – rather than simply describing them – could improve performance in questions requiring greater depth and evaluation.

Assignment 3: overall

Overall, student performance in assignment 3 was positive, with many students demonstrating a sound understanding of the topics and drawing effectively on their work placement experiences, classroom-based learning and previous assessments to support their answers. The professional discussion format allowed stronger students to showcase their ability to articulate responses clearly, use key terminology and contextualise their answers to mental health and health care settings.

However, performance varied across the cohort. While some students delivered confident, well-structured answers, others provided superficial responses lacking depth and critical evaluation, which

limited their marks. A common challenge observed was the difficulty in linking responses directly to specific legislation, frameworks or mental health scenarios when required, particularly in questions focused on safeguarding and physiological measurements.

The strongest performance was noted in questions related to teamwork and communication, where students could easily reference role play activities and placement experiences. Conversely, questions requiring evaluation, contextualisation to mental health-specific scenarios or the integration of legislation proved more challenging.

Providers who utilised the guidance questions effectively supported students in achieving higher marks, although instances of probing beyond the guidelines were flagged as malpractice. Digital recording quality showed significant improvement, aiding the accuracy and fairness of marking.

Across the cohort, there were noticeable differences in the application of English skills. Some students demonstrated strong written and verbal communication, using key terminology effectively and articulating their responses with clarity. These students were also able to contextualise their answers well to mental health and health care settings, which strengthened the quality of their discussions. Others, however, struggled to express their ideas fully, leading to responses that lacked precision or depth.

Mathematics was not directly relevant to the assessment; however, time management remains an area for improvement. Some students did not effectively use the full 60 minutes available, which limited their ability to expand on responses and access higher mark bands. Providers should continue to encourage students to pace themselves appropriately to maximise their performance.

Digital skills were applied effectively, with clear evidence that providers have acted on previous feedback to improve the quality of recordings. Enhanced sound quality and video clarity supported the examining team in accurately awarding marks. It is considered good practice for providers to ensure recordings capture both the student and the tutor, along with the surrounding environment. This not only supports assessment integrity but also reduces the risk of malpractice allegations where off-camera prompts could be a concern, ensuring a fair and transparent process for all candidates.

In summary, while the overall standard of performance was good, future cohorts would benefit from further preparation on linking theoretical knowledge to practical scenarios, using legislation accurately and developing deeper evaluative skills to reach the higher mark bands.

Document information

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