Non-Exam Assessment (NEA)

NCFE CACHE Level 1/2 Technical Award in Health and Social Care (603/7013/0)

Learner version

October 2024 release

v1.1

Introduction

The non-exam assessment (NEA) is a formal synoptic assessment that requires you to independently apply an appropriate selection of knowledge, understanding, skills and techniques, developed through the full course of study, in response to a real-world situation, to enable you to demonstrate an integrated connection and coherence between the different elements of the qualification.

The NEA will contribute **50%** towards the overall qualification grade; therefore, it is important that you produce work to the highest standard that you can. You must not start the NEA until you have been taught the full course, to ensure that you are in the best position to complete the NEA successfully.

What is synoptic assessment?

Synoptic assessment is an important part of a high-quality vocational qualification because it shows you have achieved a holistic understanding of the sector and that you can make effective connections between different aspects of the subject content and across the breadth of the assessment objectives (AOs) in an integrated way. The Department for Education (DfE) has consulted with awarding organisations and agreed the following definition for synoptic assessment:

'A form of assessment which requires a candidate to demonstrate that they can identify and use effectively in an integrated way an appropriate selection of skills, techniques, concepts, theories, and knowledge from across the whole vocational area, which are relevant to a key task.'

Synoptic assessment enables you to show that you can transfer knowledge and skills learnt in one context to resolve problems raised in another. To support the development of a synoptic approach, the qualification encourages you to make links between elements of the course and to demonstrate how you have integrated and applied your increasing knowledge and skills.

As you progress through the course, you will use and build upon knowledge and skills learnt across units. The NEA will test the learners' ability to respond to a real-world situation.

Information for learners

Introduction

The NEA will be assessed holistically using a levels of response marking grid and against five integrated AOs. These AOs and their weightings are shown below.

Assessment objectives (AOs)
AO1: Recall knowledge and show understanding The emphasis here is for learners to recall and communicate the fundamental elements of knowledge and understanding. **16 marks (19.04%)**
AO2: Apply knowledge and understanding The emphasis here is for learners to apply their knowledge and understanding to real-world contexts and novel situations. **20 marks (23.80%)**
AO3: Analyse and evaluate knowledge and understanding The emphasis here is for learners to develop analytical thinking skills to make reasoned judgements and reach conclusions. **12 marks (14.28%)**
AO4: Demonstrate the application of relevant vocational skills, processes, working practices and documentation The emphasis here is for learners to demonstrate the essential skills relevant to the vocational sector, by applying the appropriate processes, working practices and documentation. **28 marks (33.33%)**
AO5: Analyse and evaluate the demonstration of relevant vocational skills, processes, working practices and documentation The emphasis here is for learners to analyse and evaluate the essential skills; processes, working practices and documentation relevant to the vocational sector. **8 marks (9.52%)**

NCFE CACHE Level 1/2 Technical Award in Health and Social Care (603/7013/0)

Non-Exam Assessment (NEA)

October release

Learner instructions

- Read the project brief carefully before you start the work.
- You **must** clearly identify and label all of the work you produce during the supervised time.
- You **must** hand in all of your work to the supervisor at the end of each timed session.

Learner information

- This NEA will assess your knowledge and understanding from across the qualification.
- The maximum mark for this NEA is **84**.
- The maximum completion time for this NEA is **13 hours** (plus **2 hours** preparation and research time).
- All of the work you submit **must** be your own.

Resources

- You have been provided with the following documents to use during the NEA:
  - Appendix 1 – (Individual profile compiled by a care worker) – required for Tasks 1 and 3 (a)
  - Appendix 2 – (Care professional – health and wellbeing report) – required for Tasks 3 (a) and 4.

Please complete the details below clearly and in BLOCK CAPITALS.

Learner name	
Centre name	

Centre number		Learner number	

Learner signature	

Preparation and research task

Maximum time: 2 hours

In addition to the allocated assessment time for this NEA, you are permitted to spend a maximum of **2 hours** to undertake research and develop a research pack that you can refer to during the formal NEA assessment time. During this 2-hour period, you may access all learning materials, the internet and other published materials.

You should use this time to create your own research pack, and it is this pack alone that you may use during the allocated time given to the NEA. This is the only support material that is permitted during the completion of NEA tasks (unless otherwise stated within each of the task instructions).

All research and data used in your final NEA **must** be referenced appropriately. As a minimum this **must** include the following:

- the use of quotation marks to clearly identify any passages not of your own words
- date accessed (websites only)
- name of source / author.

Evidence requirements: research pack of no more than four sides of A4, font size 12 (if word processed), to be returned to your assessor at the end of each task / session and submitted with the completed NEA.

Formal non-exam assessment (NEA)

Maximum completion time

You have been provided with a total of **13 hours** to complete this NEA (plus **2 hours** for preparation and research).

You may use some or all of the time provided for each task.

You are allowed to use any remaining time allocated to one task to rework previous tasks up to the maximum time allowed.

You are not allowed to exceed the total number of hours.

You should not start your NEA until you have been taught the full course of study. This will ensure that you are in the best position to complete the NEA successfully.

Project brief

Case study

Barbara is 90 years old and lives alone in sheltered accommodation. She has signs of dementia and is beginning to forget routine activities such as drinking fluids, taking medication, and personal care and hygiene. Barbara also has macular degeneration. This causes her vision to be blurred. As a result, she is unable to prepare her own meals.

Her daughter, Elizabeth, who is 70 years old visits twice a week.

Barbara recently had a fall at home and was admitted to hospital. Hospital tests showed she was severely dehydrated and she was placed on intravenous fluids. A care package was also put in place so she could return home. She needed a week in hospital to recover.

Carers now visit Barbara four times a day to help with washing, dressing, toileting, mealtimes, and the taking of medication. Barbara wants to do as much as she can independently but understands she needs help. She has requested female only carers to support her.

Before her health deteriorated, Barbara had many hobbies including gardening and knitting. She enjoyed meeting her neighbours and attending activities such as bingo and quiz nights in the sheltered accommodation communal lounge. Barbara wants to do some of these activities again in the future.

You have been asked to work with other professionals in supporting Barbara's care needs and preferences and to take an active part in planning her care now she has left hospital.

As you work through the tasks, you **must** refer back to the above case study in addition to:

- Barbara's individual profile, completed by the care worker (appendix 1)
- the health and wellbeing report completed by the care professional (appendix 2).

These documents will help you to produce a care plan, an activity plan and a risk assessment for Barbara's ongoing care and development following her return home.

Assessment tasks

Task 1

Care planning – assess and implement	
Maximum time	**4 hours**
Content areas assessed	1. Health and social care provision and services 2. Job roles in health and social care and the care values that underpin professional practice 3. Legislation, policies and procedures in health and social care 4. Human development across the life span 5. The care needs of the individual 6. How health and social care services are accessed 7. Partnership working in health and social care 8. The care planning cycle
Assessment objectives (AOs)	AO1 – 4 marks AO2 – 4 marks AO3 – 4 marks AO4 – 12 marks

You are required to:

Use the case study and individual profile completed by the care worker (appendix 1) to **assess** Barbara's care needs on leaving the hospital.

- **write** a report of your assessment on Barbara's care needs and preferences
- **create** a care plan that will demonstrate how Barbara's individual care needs and preferences will be met during the first month at home.

Your evidence **must** include:

- Barbara's support needs and current care
- Barbara's personal objectives for the future
- the types of support required to meet Barbara's individual needs and preferences, including the care values and working with other professionals.

[24 marks]

Evidence	• Written report and care plan (word processed or handwritten).

Task 2

<table>
<tr><td colspan="2">Health and safety – procedures</td></tr>
<tr><td>Maximum time</td><td>1 hour</td></tr>
<tr><td>Content area assessed</td><td>3. Legislation, policies and procedures in health and social care</td></tr>
<tr><td>Assessment objectives (AOs)</td><td>AO1 – 4 marks
AO2 – 4 marks
AO3 – 4 marks</td></tr>
<tr><td colspan="2">Personal information, such as Barbara’s individual profile and care plan, need to be kept confidential and stored appropriately, following safe working practices.

You are required to:

Consider how to maintain safe working practices in relation to confidentiality around Barbara’s personal information, such as her individual profile and care plan.

• analyse and evaluate safe working practices in relation to confidentiality and record keeping
• write a safe working practice procedure to include safe use and storage of personal information.

Your evidence must include:
• reference to why Barbara’s personal information needs to be kept confidential and recorded appropriately
• clear justification for safe working practices that state why Barbara’s personal information should be used and stored appropriately.

[12 marks]</td></tr>
<tr><td>Evidence</td><td>• Written analysis and procedure (word processed or handwritten).</td></tr>
</table>

Task 3 (a)

<table>
<tr><td colspan="2">Planning an activity</td></tr>
<tr><td>Maximum time</td><td>3 hours</td></tr>
<tr><td>Content areas assessed</td><td>2. Job roles in health and social care and the care values that underpin professional practice
4. Human development across the life span
5. The care needs of the individual</td></tr>
<tr><td>Assessment objectives (AOs)</td><td>AO1 – 4 marks
AO2 – 4 marks
AO4 – 8 marks</td></tr>
<tr><td colspan="2">You are required to:

Review the case study, individual profile (appendix 1), health and wellbeing report (appendix 2), your report and care plan completed in Task 1.

• create a plan for a day’s activities based around Barbara’s care needs and her previously enjoyed activities.

Your plan for the day must include:

• suitable activities with timings (including breaks and travel where applicable)
• how each activity will support Barbara’s holistic development and meet her individual care needs
• the family member, practitioners’ or professional’s role during the activities
• resources required to support Barbara’s development.

[16 marks]</td></tr>
<tr><td>Evidence</td><td>• Activity plan for the day (written document, word processed or handwritten).</td></tr>
</table>

Task 3 (b)

Planning an activity – risk assessment	
Maximum time	**2 hours**
Content area assessed	3. Legislation, policies and procedures in health and social care
Assessment objectives (AOs)	AO1 – 4 marks AO2 – 4 marks AO4 – 4 marks
You are required to: **Consider** the activities planned in **Task 3 (a)** to **assess** any potential risks to Barbara and or others. • **create** a risk assessment template for **one** of the activities given in the plan for **Task 3 (a)** and complete the risk assessment using your template. **[12 marks]**	
Evidence	• Completed risk assessment for one of your planned activities (word processed or handwritten).

Task 4

<table>
<tr><td colspan="2">Care planning – review</td></tr>
<tr><td>Maximum time</td><td>2 hours</td></tr>
<tr><td>Content areas assessed</td><td>1. Health and social care provision and services
2. Job roles in health and social care and the care values that underpin professional practice
4. Human development across the life span
5. The care needs of the individual
7. Partnership working in health and social care
8. The care planning cycle</td></tr>
<tr><td>Assessment objectives (AOs)</td><td>AO2 – 4 marks
AO3 – 4 marks
AO4 – 4 marks</td></tr>
<tr><td colspan="2">It has now been 4 weeks since Barbara left hospital. The care professional has completed a health and wellbeing report (appendix 2) which focusses on Barbara’s ongoing holistic developmental needs.

You are required to:

Review the care professional’s health and wellbeing report (appendix 2)

• assess the extent to which Barbara’s individual needs and preferences are now being met and consider the changes required to Barbara’s care plan to support her ongoing holistic development needs.
• write a report of your findings and update your care plan created in Task 1 to take account of Barbara’s needs following her time at home during the last 4 weeks.

Your evidence must include:

• details of an analysis and evaluation of the care professional’s health and wellbeing report
• clear justification for recommended changes to Barbara’s care plan

Using a different coloured text or pen:

• update your care plan (created in Task 1) with relevant changes following the review of the health and wellbeing report and your assessment.

[12 marks]</td></tr>
<tr><td>Evidence</td><td>• Written report – with the recommended changes and why (word processed or handwritten)
• Updated care plan (word processed or handwritten).</td></tr>
</table>

Task 5

Evaluation of your care plan	
Maximum time	**1 hour**
Content area assessed	8. The care planning cycle
Assessment objective (AO)	AO5 – 8 marks
You are required to: • **complete** an evaluation of the updated version of your care plan from **Task 4**. Your evaluation **must** include: • how well your updated care plan now records and outlines Barbara's care and support needs following her 4 weeks at home • how well your care plan now meets Barbara's holistic needs and preferences. **[8 marks]**	
Evidence	• An evaluation (word processed or handwritten).

Appendix 1

Individual profile compiled by care worker.

You are required to use this document for Task 1.

Setting	Rowan Court Sheltered Accommodation
Name	Barbara Allen
Age	90
Family background notes	Barbara lives in a one-bedroom ground floor flat. It is in sheltered accommodation, which has communal gardens, a laundry room, and a social club. Residents can meet at the club for activities such as afternoon tea, bingo, and quizzes. Barbara is a widow. She has one daughter, Elizabeth, who lives locally and visits two times a week. Elizabeth has been making meals for Barbara and freezing them so she can have a home cooked meal each day. She also does Barbara's shopping and phones her every evening.
Health and wellbeing notes	Barbara was once very active. Since she has started to show signs of dementia, she has become more isolated and is not wanting to go out on her own. She has been forgetting to cook meals and drink regularly. She will often return to bed during the day thinking it is night-time. Her family are still waiting for a diagnosis from the memory clinic for dementia. She is unable to remember names and her short-term memory is greatly affected. She was diagnosed many years ago with irritable bowel syndrome (IBS) which can cause abdominal cramps and diarrhoea or constipation. It is therefore essential for Barbara to have a balanced healthy diet. Barbara had her fall when she was trying to get out of bed during the night. Hospital tests showed she was very dehydrated and weak. She needed a week in hospital to recover. Barbara now wears incontinence pads because she cannot always get to the toilet in time. Barbara is unable to walk unaided. Barbara has a walking stick and a walking frame. Barbara wears glasses and has macular degeneration which blurs her vision. She has regular visits to the optician and hospital to monitor this condition.

Social activities	Before her health degenerated, Barbara would do her own laundry every Thursday and meet her neighbours outside in the communal lounge. She would also attend bingo each week on a Wednesday evening and regularly visit the Royal Horticultural Society (RHS) gardens and local garden centres. Her daughter takes her out each week for fish and chips, and a drive out to the seaside or to her home.
Other professional involvement	Care workers Physiotherapist GP Occupational therapist
Care worker comments	Barbara is a friendly lady who is particularly frail since her fall. She welcomes the visit of the care staff and will engage in conversation. Barbara needs support with toileting, washing and dressing. Although she can do these tasks herself, she is not strong enough to complete them safely. Barbara needs to be given her medication as she will forget to take it. She also needs her food served to her. She needs to be reminded to drink and to keep hydrated. Barbara can communicate her needs and feelings; however, this can change frequently.

Appendix 2

You are required to use this resource for Task 3 (a) and 4.

Care professional – health and wellbeing report for:

Name: Mrs Barbara Allen

DOB: 20.1.1934

Address: 19 Rowen Court
Romford
Essex
RO29 CHB

(This report was compiled 4 weeks after Barbara's care package was put in place)

Physical	Barbara's health continues to improve but she will still need medication for pain relief. This is now given as a water-soluble tablet. Barbara appears to be coping well with the medication and her GP is satisfied with her progress. Barbara is gradually regaining mobility. There are still some safety concerns that Barbara will fall or try to walk unaided when carers or her daughter are not present. She is now more confident when she is standing and she can walk short distances with her walking frame. Her muscle strength and mobility will continue to improve as she mobilises and exercises more. Barbara has recently had a new bedframe and air flow mattress delivered to decrease the likelihood of pressure sores. A grab rail and bed guard have been installed, to stop her rolling out of bed. The physiotherapist has suggested daily exercises and Barbara has been encouraged to do all these exercises. Barbara is very slowly regaining coordination and fine motor skills. She is still having difficulty with some personal hygiene tasks such as pulling up incontinence pants and dressing. The carers continue to visit four times a day. In the morning, they get Barbara up and help with washing and dressing. They visit at lunch time, in the afternoon and put her to bed in the evening. Barbara has a small appetite and will refuse to eat all of the meals given to her. She swallows food with no problems, but eating is a slow process. Carers need to remind her to drink.
Cognitive	Barbara will listen to her music and watch television. Her daughter has given her suitable reading materials, colouring books and resources that support her impaired vision, so she is able to engage. Barbara has short-term memory loss.

Social and emotional	Barbara enjoys visits from her daughter and neighbours, and she is always keen to engage in conversation. Barbara misses meeting up with her friends and going out in the car visiting Royal Horticultural Society (RHS) gardens, she would benefit from more social interactions. Barbara appears emotionally well in spite of her memory loss. She does not appear to be frustrated and is more accepting when she cannot remember facts.

Name: Pat Francis (care professional) **Signed:** P.M Francis **Date:**11 April 2024

Documentation

Declaration of authenticity

The learner and assessor **must** complete the form at the end of the assessment and before any marking takes place. The assessor **must** check the number of tasks submitted by the learner is accurate.

The completed form **must** be retained within the centre and is not to be sent to the moderator or NCFE unless specifically requested.

Learner name:	
Tasks submitted:	
Learner declaration:	
I certify that the work submitted for this NEA is my own. I have clearly referenced any sources used in the work. I understand that false declaration is a form of malpractice.	
Learner signature:	
Date:	

Assessor name:	
Assessor declaration:	
I certify that the work submitted is the learner's own. The learner has clearly referenced any sources used in the work. I confirm that all work was conducted under conditions designed to assure the authenticity of the learner's work.	
Assessor signature:	
Date:	

Note: once completed, the declaration of authenticity **must** be stored securely within the centre, in line with NCFE Regulations for the Conduct of NEA – Non-Exam Assessment. A copy of this declaration form **must** be made available to NCFE upon request.

GDPR consent

Section A: this section must be completed by the learner

- NCFE may select your work for use at teacher training or standardisation events. Your work will be anonymised by removing your name. All materials will be reviewed regularly and will be removed if no longer required.
- NCFE may select your work at some point in the future for use in teaching and learning resources published on the NCFE website. Your work would be anonymised by removing your name. All materials will be reviewed regularly and will be removed if no longer required.
- You understand that this agreement may be terminated at any time through written request.
- For further details about how we process your data, please refer to the legal information section on the NCFE website.

Please tick the option that applies, and sign and date the boxes below:

	Tick one only
I consent to my work being used in the manner detailed in section A	
I **do not** consent to my work being used in the manner detailed in section A	
Learner signature:	
Date:	

Section B: this section must be completed by any participants who feature in the work

Over 13 years old

- I am over 13 and I give my permission for my video and / or photographic image to be used as detailed in section A (above).

Under 13 years old

- I give my permission for my child's video and / or photographic image to be used as detailed in section A (above).

Name of participant (printed)	**Participant / Parent / Carer signature**	**Date**

If any of the participants have declined permission, please tick here: ☐