Meeting HCPC Standard 5

Embedding Equity, Diversity and Belonging into your practice

Royal College of Occupational Therapists

RCOT practice resource: Meeting HCPC Standard 5 – recognising the impact of culture, equality and diversity on practice; and embedding equity, diversity and belonging

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Part 1. Purpose and foundations

1. Introduction

Why does this guide matter?

Occupational therapy is built on the belief that everyone should have equal opportunity to take part in meaningful occupations that support health, wellbeing and inclusion. To achieve this, practice must be safe, effective, inclusive and non-discriminatory.

What's changed?

In 2023, the Health and Care Professions Council (HCPC) updated its Standards of Proficiency for occupational therapists. Standard 5 now requires registrants to:

'Recognise the impact of culture, equality and diversity on practice and practise in a non-discriminatory and inclusive manner.'

This update makes explicit the expectation that occupational therapists must embed equity, diversity and belonging into every aspect of their work, not as an optional extra but as a professional standard.

How will this guide help me?

We've created this resource to support occupational therapists in applying Standard 5 in daily practice. It offers:

- practical examples and reflective prompts that illustrate what Standard 5 looks like in action
- guidance aligned with UK equality legislation and case law, so practice decisions are grounded in professional and legal responsibilities
- real-world applications at the micro, meso and macro levels, showing how inclusive practice can be embedded with individuals, within teams and services and across wider systems
- insights from lived experience, research and professional standards, ensuring that diverse voices and perspectives shape occupational therapy.

How can I use this guide as an RCOT member?

We've designed this guide as a **working resource**, not a static manual. It can be used in multiple ways to support your continuing professional development (CPD) and evidence for HCPC re-registration.

- **For individual CPD** – use the reflection questions and exercises to guide journaling, portfolio entries and self-assessment.
- **In supervision** – select one section or sub-standard as a structured reflection tool for case discussions or developmental reviews.
- **With teams or services** – run group discussions, CPD workshops, or away days using the case examples as prompts for collective learning.
- **For student education** – adapt the examples and exercises to support placement supervision and to model inclusive, rights-based practice.
- **For service development** – apply the frameworks and tools to review how equity, diversity, and belonging are embedded in your workplace.

What makes this guide different?

It is intentionally **interactive and adaptable**. As new knowledge, co-produced approaches and social contexts evolve, this resource can grow with the profession.

By embedding **equity, diversity and belonging** in practice, occupational therapists can:

- challenge injustice
- dismantle oppressive systems
- address health inequities
- build a profession where both the people accessing services and those delivering them are enabled to thrive.

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2. Why we use equity, diversity and belonging (EDB)

Why not just 'equality, diversity and inclusion (EDI)'?

The Health and Care Professions Council (HCPC) uses the term equality, diversity and inclusion (EDI). This guide adopts the broader term equity, diversity and belonging (EDB) to better reflect the realities of occupational therapy.

What does each part mean for me as an occupational therapist?

- **Equity** – Not everyone starts from the same place. Equity means recognising systemic inequalities and tailoring support to remove barriers, so that people can achieve fair outcomes in occupation and society.

  Example: Providing an interpreter for someone who uses British Sign Language is an equitable step, not just an 'equal' one.

- **Diversity** – People differ in many ways; race, culture, religion, gender identity, sexual orientation, age, disability, neurodiversity and socioeconomic status. Diversity reminds us who's in the room, but representation alone is not enough. Occupational therapists must also share power and ensure all voices are heard.
- **Belonging** – Belonging goes beyond inclusion. It means creating spaces where people feel safe, valued and able to be themselves without fear of judgement, marginalisation or discrimination. In occupational therapy, belonging is essential for participation in meaningful life roles.

Why does this matter for occupational therapy?

Adopting EDB positions occupational therapy as a profession that is:

- **relational:** focused on authentic human connection
- **rights-based:** grounded in equity and social justice
- **transformative:** moving beyond compliance to actively dismantle systemic barriers.

This approach keeps the focus not only on those who access occupational therapy but also on the **psychological safety and wellbeing of the workforce** itself.

Reflective question:

When I think about equity, diversity, and belonging in my practice, am I only aiming for compliance

or am I working towards genuine justice and belonging?

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3. Inclusive language: Supporting equity, belonging and understanding

Why does language matter in occupational therapy?

Language is never neutral. The words we use shape how people feel, how relationships are formed and whether interactions reinforce or dismantle inequality. Inclusive language is therefore a practical step towards equity and belonging.

Why does this guide say ‘people’ instead of ‘service users’?

The Health and Care Professions Council (HCPC) uses the term ‘service users’ in its standards and regulatory materials. While this aligns with policy and legal frameworks, many people find it depersonalising or simplistic. It can suggest a passive or transactional relationship with care rather than one based on partnership and mutual respect.

Our guide instead uses terms such as ‘people accessing occupational therapy’ or simply ‘people’. This choice reflects occupational therapy’s identity as a person-centred, relational and rights-based profession. It acknowledges that:

- occupation happens in people’s lives, communities and identities, not just within services
- words that centre people’s humanity, support dignity, autonomy and belonging.

How do occupational therapists use inclusive and accessible language?

- **Plain language**: Avoid jargon and explain terms in ways that are clear and accessible.
- **Anti-oppressive language**: Be mindful of avoiding terms that are racist, ableist, ageist, sexist or otherwise discriminatory.
- **Say what you mean**: Where acronyms are used, write out the full term as well. Feedback from neurodivergent communities is that acronyms can be exclusionary.
- **Affirming identities**: Use names, pronouns and identity terms chosen by the person.

What difference does language make?

- It signals whether people are being seen as partners in their care or as passive recipients.
- It communicates dignity and belonging, helping to create psychologically safe spaces.
- It influences how colleagues, students and wider systems talk about and treat those accessing occupational therapy.

Reflective question for occupational therapists:

Do the words I use in reports, conversations and documentation affirm dignity and belonging, or could they unintentionally reinforce exclusion and stigma?

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4. Affirmation in practice

What is affirmation and why does it matter in occupational therapy?

Affirmation is more than a communication technique; it‘s a core relational skill that underpins every part of the Health and Care Professions Council (HCPC) Standard of Proficiency 5. It’s the active

process of recognising, validating and respecting a person's identity, values and lived experience before moving into problem-solving or education.

What does affirmation look like in practice?

In occupational therapy, affirmation involves:

- **acknowledging** the perspective and meaning a person places on their situation
- **reflecting understanding** so the person feels genuinely seen and heard
- **validating emotions and cultural contexts** even when you also offer alternative approaches
- **empowering self-advocacy**, supporting the person to speak up for themselves alongside occupational therapy-led actions.

Why is this important for equity, diversity and belonging?

Affirmation:

- strengthens **trust** between occupational therapists and those they support
- reduces **power imbalances** that can silence people's voices
- enables **collaborative, person-centred decision-making**
- demonstrates respect for identity and culture, building psychological safety.

Practice example

Scenario: A Muslim occupational therapy student on placement has shared that colleagues questioned why they need breaks to pray, and that they feel excluded from handovers that are scheduled during these times.

Occupational therapy educator's response: The educator actively listens, acknowledges the impact of exclusion, and validates the student's religious needs. Together, they explore solutions such as rescheduling handovers and educating the team about prayer times.

Impact: The student feels respected and supported, team awareness improves and the placement environment becomes more inclusive for current and future students.

Reflective question for occupational therapists:

In my daily practice, do I affirm and validate first or do I move too quickly into problem-solving without recognising the person's perspective?

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5. HCPC Standard 5: Equity, diversity and inclusion in practice

What does Standard 5 require?

The Health and Care Professions Council (HCPC) Standard of Proficiency 5 sets clear expectations for all registered occupational therapists in relation to equity, diversity, and inclusion (EDI). It highlights the importance of responding appropriately to differences and embedding inclusive values throughout practice.

HCPC Standard 5:
'Registrants must recognise the impact of culture, equality and diversity on practice and practise in a non-discriminatory and inclusive manner.'

To meet this standard, occupational therapists must be able to:

5.1 Recognise the impact of differences such as protected characteristics, intersectional experiences and cultural differences on practice and be able to respond appropriately.

5.2 Understand the importance of equality, equity and inclusion and apply legislation, policies and guidance relevant to their practice.

5.3 Recognise the potential impact of own values, beliefs and personal biases (which may be unconscious) on practice and take action to ensure all service users and carers are treated appropriately and with respect and dignity.

5.4 Understand the duty to make reasonable adjustments in practice and be able to make and support reasonable adjustments in their and others' practice.

5.5 Recognise the characteristics and consequences of barriers to inclusion, including for socially isolated groups.

5.6 Actively challenge these barriers, supporting the implementation of change wherever possible.

5.7 Recognise that equality, diversity and inclusion need to be embedded in the application of all HCPC standards across all areas of practice.

(Source: HCPC Standards of Proficiency for Occupational Therapists, 2023)

How does this guide support me?

In this guide we explore each of these key points in detail, offering:

- practical, occupational therapy-specific examples
- reflective prompts to support professional development
- guidance on embedding cultural humility and anti-oppressive practice
- insights into meeting the needs of people from diverse and intersectional backgrounds
- tools to align your work with UK equality law and ethical obligations
- strategies for creating inclusive, accessible, and equitable environments for people who access occupational therapy.

Reflective question for occupational therapists:

Which part of Standard 5 do I feel most confident in applying and which area do I need to develop further in my practice?

Part 2: Legal and ethical responsibilities

Why does this part matter?

Occupational therapists must not only practise safely and effectively, but also lawfully and ethically. The Health and Care Professions Council (HCPC) Standards of Proficiency make clear that inclusive, non-discriminatory practice is both a professional responsibility and a legal duty.

What does this section cover?

Part 2 explores the legal frameworks that underpin equity, diversity and belonging in occupational therapy. These frameworks establish minimum expectations, but they also create opportunities for occupational therapists to act as advocates for justice and inclusion.

- **Equality Act and protected characteristics** sets the foundation, outlining who is legally protected from discrimination and how.
- **Interacting legislation** shows how other laws (such as the Mental Capacity Act, Mental Health Act, and Human Rights Act) connect with and sometimes complicate equality duties.
- **Reasonable adjustments vs clinical interventions** clarifies what occupational therapists are legally required to do to remove barriers and how this differs from therapeutic interventions.
- **Case law and policy developments** highlights how courts and policy shifts continue to shape equality law in practice.
- **Conflicting beliefs and values** explores how occupational therapists navigate situations where legal protections, personal values and professional standards intersect.

Why is this important for occupational therapy?

Understanding legal and ethical responsibilities ensures occupational therapists can:

- protect people's rights and dignity
- navigate complex and sometimes conflicting duties with confidence
- recognise that equality legislation is not only a legal requirement but a framework for creating inclusive, equitable services.

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1. Equality Act 2010 and protected characteristics

What is the Equality Act 2010?

The Equality Act 2010 is the key piece of anti-discrimination legislation in England, Scotland, and Wales. It provides legal protection from unfair treatment and supports the creation of a more inclusive and equal society.

The Act identifies **nine protected characteristics**:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

Why does this matter for occupational therapy?

Understanding and applying the Equality Act is essential for occupational therapists to deliver person-centred, lawful and ethical care. It also underpins many of the expectations set out in the Health and Care Professions Council (HCPC) Standards of Proficiency.

What are my responsibilities as an occupational therapist?

- **Make reasonable adjustments** to ensure accessibility and equitable participation for disabled people and others disadvantaged by structural barriers. This includes adjusting environments, communication methods and therapy expectations to meet individual needs.

- **Avoid discriminatory assumptions** by recognising that each person's identity and experience are unique. Occupational therapists should challenge stereotypes, remain open-minded and avoid allowing biases to shape assessments, goals or intervention plans.
- **Recognise intersectional disadvantage**, understanding that people may face multiple and overlapping forms of discrimination.

Example: A Black autistic woman may experience racism, ableism, and gender bias that compound her exclusion from meaningful occupation.

How should I apply the Equality Act in practice?

Occupational therapists must embed the Equality Act as a legal requirement and as a guiding ethical principle.

This means:

- seeing the Act not as a limitation, but as an opportunity
- using it to ensure occupational therapy is inclusive and justice-oriented
- valuing every person's right to participate in meaningful activities that reflect their identity, culture and aspirations.

Reflective question for occupational therapists:
In my practice, do I see equality law as a 'compliance exercise'; or as a tool to actively dismantle barriers and promote justice in people's everyday occupations?

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2. Interacting legislation

Does the Equality Act 2010 stand alone?

No. While the Equality Act 2010 is central to promoting anti-discrimination and equality, it does not operate in isolation. Occupational therapists often work in complex environments where multiple legal frameworks apply at the same time. These laws intersect with the Equality Act and must be applied in ways that uphold people's rights and reduce restrictive or discriminatory practices.

Key legislation and why it matters for occupational therapy

Equality Act 2010

- **Purpose:** Protects against discrimination based on nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
- **Application for occupational therapists:** Ensure equitable access to services, make reasonable adjustments and challenge discrimination whenever it occurs.

Mental Capacity Act 2005 (England and Wales)

- **Purpose:** Provides a framework for supporting decision-making for people aged 16 and over who may lack capacity for a specific decision.
- **Application for occupational therapists:** Assess capacity carefully, avoid assumptions based on disability or communication style and promote supported decision-making so people remain central to their care.

Mental Health Act 1983 (amended 2007) (England and Wales)

- **Purpose:** Sets out the legal framework for the assessment, treatment, and rights of people with mental health needs, including those detained under the Act.
- **Application for occupational therapists:** Ensure continued access to meaningful occupation, use the least restrictive options and actively involve people in care planning.

Care Act 2014 (England)

- **Purpose:** Places duties on local authorities to promote wellbeing, independence and prevention.
- **Application for occupational therapists:** Ensure assessments address individual needs and goals, and challenge indirect exclusion due to discrimination or structural barriers.

Human Rights Act 1998 (UK-wide)

- **Purpose:** Embeds fundamental rights such as dignity, liberty, respect for private and family life, and protection from degrading treatment.
- **Application for occupational therapists:** Be especially mindful of rights when working in restrictive environments. Ensure any restrictions are lawful, proportionate and time-limited.

Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards (LPS) (England and Wales)

- **Purpose:** Protects rights when a person's liberty is restricted in a care setting.
- **Application for occupational therapists:** Consider the impact of restrictions on participation in meaningful occupations, advocate for dignity and choice and record clear justifications for recommendations.

Children Act 1989 and 2004 (England and Wales)

- **Purpose:** Places duties on professionals to safeguard and promote the welfare of children.
- **Application for occupational therapists:** Centre equality, participation and developmental rights in work with children, adapting services to diverse cultural, communication and family needs.

3. National variations in equality and related legislation

Scotland

- Equality Act 2010 applies alongside the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.
- Public authorities must publish equality outcomes, assess policy impact, gather diversity data, and report on pay gaps.

Role for occupational therapists: Contribute to equality impact assessments, making sure that service changes are inclusive and non-discriminatory.

Wales

- Equality Act 2010 applies alongside the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011.
- Public bodies must publish strategic equality plans and set measurable objectives.

Role for occupational therapists: Engage in co-production and ensure interventions align with these objectives.

England

- Equality Act 2010 applies, with duties under the Public Sector Equality Duty (PSED).

- Implementation is often local.

Role for occupational therapists: Take a proactive role in advocating for equality audits, inclusion strategies and co-produced service improvements.

Northern Ireland

- Equality is governed by Section 75 of the Northern Ireland Act 1998 and related legislation, including the Disability Discrimination Act 1995, Race Relations (Northern Ireland) Order 1997, and Fair Employment and Treatment (Northern Ireland) Order 1998.
- Public authorities must promote equality across a broader range of categories, including political opinion and dependency status.

Role for occupational therapists: Be familiar with regional processes including Equality Impact Assessments (EQIAs) and ensure services reflect Northern Ireland's broader equality framework.

Practice example: Balancing the Mental Capacity Act and the Equality Act

Scenario: An occupational therapist is working with an older adult with dementia in a residential care home. The staff assume the person lacks capacity to decide whether to take part in cooking groups because of their diagnosis. The person expresses a clear wish to take part, even though they sometimes need prompts and adaptations.

Occupational therapist's response: The occupational therapist applies the Mental Capacity Act 2005, assessing capacity for this specific decision rather than assuming incapacity. They also draw on the Equality Act 2010, ensuring reasonable adjustments are made to support participation (simplified instructions, adapted equipment, extra supervision). The occupational therapist records the rationale clearly and involves the person in co-designing how they take part.

Impact: The person joins the cooking group safely and meaningfully. Staff gain a better understanding of how capacity must be assessed decision by decision, and the service reduces exclusionary practices based on diagnosis. This promotes dignity, rights and equitable access to meaningful occupation.

Reflective question for occupational therapists:

When different laws apply in my setting, do I apply them in a way that protects people's rights and maximises inclusion, or do I risk allowing one piece of legislation to unintentionally override another?

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4. Reasonable adjustments and clinical interventions in practice

Why do reasonable adjustments matter in occupational therapy?

The Equality Act 2010 places a legal duty on occupational therapists to make reasonable adjustments for people who meet the Act's definition of disability. This duty sits alongside other legal frameworks such as the Human Rights Act 1998 and, in some contexts, the Care Act 2014. All emphasise the need for equitable access and participation.

How does the Equality Act define disability?

A disabled person is defined as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. While this definition is grounded in the medical model of disability (focusing on impairments),

occupational therapy is better aligned with the social model of disability, which sees disability as the result of:

- inaccessible environments
- systemic exclusion
- attitudinal barriers.

Occupational therapists are expected to understand the social model and reflect it in practice by:

- enabling participation in meaningful occupations
- advocating for access
- removing environmental, systemic and attitudinal barriers
- recognising society's role in creating disabling conditions.

What are reasonable adjustments?

- Legal changes or adaptations to remove or reduce barriers experienced by disabled people.
- A statutory right, not an act of kindness or an 'extra'.
- Anticipatory services must think ahead and design inclusively, not wait until someone asks.

Examples in occupational therapy practice

- Providing information in accessible formats (easy read, large print, audio).
- Allowing extra time for assessments or placement tasks.
- Offering remote sessions or home visits if travel is a barrier.
- Using alternative communication tools or interpreters.
- Creating sensory-friendly environments.
- Adjusting shift times or providing regular breaks for staff or students.

These duties apply to people accessing occupational therapy, as well as occupational therapists, students, educators and team members.

How are reasonable adjustments different from clinical interventions?

Reasonable adjustment: Removes a barrier so the person can access therapy or work on equal terms with others.
Example: Relocating a session to a wheelchair-accessible room with adjustable-height equipment.

Clinical intervention: A therapeutic activity or strategy to address an occupational performance issue.
Example: Teaching energy conservation techniques.

Access to therapy is a right, not a treatment. Ensuring therapy is available, understandable and usable is the foundation of equitable care.

What does the HCPC expect?

The HCPC Standard 5.4 states that occupational therapists must:

'Understand the duty to make reasonable adjustments in practice and be able to make and support reasonable adjustments in their and others' practice.'

Meeting this standard requires more than responding to individual requests. It means:

- anticipating common access barriers
- embedding inclusive approaches by default
- supporting colleagues, students and team members who require adjustments.

This proactive stance is not only a regulatory requirement, but also essential to building inclusive, rights-based services that uphold equity, dignity and participation for all.

Practice example: Anticipating adjustments in student placements

Scenario: A student occupational therapist with dyslexia begins a placement. They are anxious about disclosing their needs, worried it will be seen as a weakness.

Occupational therapist educator's response: The educator introduces a placement induction checklist that includes a standard discussion of learning needs and adjustments for all students. This normalises the conversation, allowing the student to share openly. Adjustments include extra time for written notes and access to text-to-speech software.

Impact: The student feels safe and supported, performs effectively and the placement environment becomes more inclusive for future students.

Reflective question for occupational therapists:

Do I treat reasonable adjustments as an optional add-on, or do I anticipate and embed them into my practice as a professional duty and a foundation of equity?

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5. Incorporating recent case law and policy developments

Why does case law matter for occupational therapy?

Equality law is not static. Court rulings and policy developments shape how the Equality Act 2010 is interpreted and applied in practice. For occupational therapists, this means staying informed about legal changes that affect people's rights, service design, and inclusive environments.

Key cases shaping practice

Forstater v CGD Europe (2021)

Ruling: Gender-critical beliefs (including the view that sex is immutable) are protected under the Equality Act 2010 as a philosophical belief.

Implication: Protection for belief does not give licence to misgender others, deny identity or create unsafe environments.

Balance: The law protects belief *and* protects people with the characteristic of gender reassignment.

For Women Scotland v The Scottish Ministers (2025)

Ruling: The UK Supreme Court held that the words 'man' and 'woman' in the Equality Act 2010 refer specifically to biological sex, even for those with a Gender Recognition Certificate (GRC).

Implication: This has consequences for policies on single-sex spaces (e.g. toilets, hospital wards, shelters).

Balance: The protected characteristic of gender reassignment remains fully in place. Discrimination against trans, non-binary and gender-diverse people remains unlawful.

What does this mean for occupational therapy practice?

Occupational therapists must continue to provide care that is affirming, compassionate and lawful by:

- respecting affirmed gender identities in communication, documentation, and therapeutic relationships
- offering gender-neutral options or single-user facilities where biological definitions limit access to gendered spaces
- making reasonable adjustments to protect both physical and psychological safety.

How does this link to equity, diversity and belonging (EDB)?

These legal developments can support EDB work by encouraging occupational therapists to:

- update service policies, audits, and inclusion statements
- advocate for inclusive and trauma-informed service design
- challenge discriminatory practice, while working within legal boundaries and duties.

Why is this significant for occupation?

A person's gender identity shapes:

- their sense of self and daily roles
- self-care routines
- social participation
- access to meaningful activity

Upholding someone's right to engage in occupation requires acknowledging and affirming who they are.

Practice example: Respecting gender identity in a hospital ward

Scenario: A non-binary person is admitted to a rehabilitation ward. Staff are unsure whether to allocate them to a male or female bay, and the person feels anxious about being misgendered.

Occupational therapist's response: The occupational therapist ensures the person's pronouns and identity are respected in all documentation and conversations. They advocate for access to a private single-user bay and provide education to staff about inclusive communication.

Impact: The person feels safe, respected, and able to engage fully in therapy. The team gains confidence in inclusive practice and updates ward policy to ensure future consistency.

Reflective question for occupational therapists:

Am I confident in how recent case law affects service design and my everyday practice, and do I actively affirm people's gender identities while navigating legal complexities?

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6. Conflicting beliefs and values

Why is this an issue in occupational therapy?

Occupational therapists work with people, families, communities, students and colleagues who hold

a wide range of personal, cultural and religious beliefs. Sometimes these beliefs can come into conflict with each other, with equality law, or with the professional standards that occupational therapists must uphold. Navigating these tensions requires sensitivity, reflection and a clear grounding in legal and professional responsibilities.

Where might conflicts arise?

- A staff member's religious beliefs about sexuality conflicting with inclusive practice for LGBTQIA+ people.
- A colleague holding gender-critical beliefs (protected as a philosophical belief) while working alongside trans and non-binary people.
- Families requesting gender-specific care that clashes with service capacity or policies.
- A person accessing occupational therapy expressing racist views that cause distress or harm in a group setting.
- A colleague making ableist assumptions, such as questioning the competence of an occupational therapist with a disability, despite their professional registration.
- A person expressing values that differ from those of the occupational therapist, for example, insisting on independence when the therapist emphasises interdependence.

What does the law say?

- Equality Act 2010 protects religion or belief *and* protects people with other protected characteristics such as sexual orientation, race, disability and gender reassignment.
- HCPC Standards of Proficiency and Standards of Conduct, Performance and Ethics require occupational therapists to treat all people with dignity and respect, regardless of personal views.
- Case law (e.g. Forstater 2021) confirms that beliefs may be protected, but this does not permit discriminatory or harmful behaviour.

How should occupational therapists respond?

- Acknowledge beliefs without compromising inclusion. Respect that people hold different views, while being clear that discriminatory behaviour is unacceptable.
- Set boundaries. Make clear when a belief or behaviour crosses into exclusion or harm.
- Prioritise safety and dignity. The rights of people accessing occupational therapy to safe, respectful and affirming care must be upheld.
- Use reflection and supervision. Explore personal discomfort or uncertainty in a safe space.
- Report and record. Use your organisations reporting tools to ensure accountability and follow-up when incidents occur.

Practice examples: Responding to conflicting beliefs and values

Example 1: Supporting inclusion despite conflicting beliefs about sexuality

Scenario: An occupational therapist supervising a student learns the student is uncomfortable working with a same-sex couple due to religious beliefs.

Response: The supervisor acknowledges the student's beliefs but makes clear their professional duty to provide equitable, non-discriminatory care. They hold a reflective discussion about balancing personal values with professional responsibilities and share resources on inclusive practice and equality law.

Impact: The student learns how to manage personal beliefs in a professional context. The couple receives respectful, affirming support.

Example 2: Addressing racist behaviour in a group setting

Scenario: During a community occupational therapy group, one participant makes a racist remark toward another. The group atmosphere becomes tense and the targeted person withdraws.

Response: The occupational therapist intervenes immediately, naming the behaviour as unacceptable and reinforcing group agreements about respect. They check in with the targeted person to validate their experience and adapt the session to ensure their comfort. The occupational therapist then meets one-to-one with the person who made the remark to explain why it was harmful and set expectations for future conduct. An incident report is completed to ensure accountability, and the issue is reflected on in supervision to plan next steps.

Impact: The targeted person feels supported and safe. The group learns that racism will not be tolerated. The person who made the remark is held accountable and offered the opportunity to learn. The organisation has a formal record to monitor patterns of discrimination.

Example 3: Challenging ableist assumptions in the workplace

Scenario: A disabled occupational therapist who uses a wheelchair is excluded from home visit allocations because colleagues assume they can't do the work.

Response: The lead occupational therapist addresses this in a team meeting, clarifying that allocation must be based on skills and reasonable adjustments, not assumptions about disability. They also meet one-to-one with colleagues who made the decision, explaining why the assumptions were ableist and reinforcing expectations for equity. An incident report is completed to ensure accountability and supervision is used to plan anti-ableism training for the team.

Impact: Work is allocated fairly. The disabled occupational therapist can contribute fully. Colleagues are directly challenged to reflect on their bias. A formal report ensures organisational accountability and follow-up.

Reflective question for occupational therapists:
When personal or cultural beliefs come into conflict with professional responsibilities, how do I ensure that my practice upholds dignity, inclusion and safety, while addressing discriminatory behaviour appropriately?

Part 3: Practical application and accountability

Why does this part matter?

Legal frameworks establish the baseline for equity and inclusion, but laws alone do not create belonging. Occupational therapists bring these duties to life through day-to-day practice, relationships and leadership. Part 3 focuses on the internal tools and approaches that occupational therapists need to apply the law, uphold professional standards and create genuinely inclusive environments.

What does this section cover?

- **Core concepts:** Anti-oppressive practice, cultural humility and intersectionality provide the values and lenses that underpin inclusive practice.
- **Micro, meso, macro practice:** Shows how occupational therapists can act at the individual, team/service and system levels to challenge inequality.
- **Reflective practice and managing bias:** Supports ongoing self-awareness, helping occupational therapists recognise and address the influence of personal values, beliefs and unconscious bias.
- **Supporting colleagues and students:** Explores how equity, diversity and belonging apply in supervision, education and workforce development.
- **Building inclusive services and teams:** Looks at the leadership role occupational therapists can take in shaping cultures of equity, belonging and justice.

Why is this important for occupational therapy?

This part recognises that inclusive practice is not just about knowing the law but about:

- building awareness of power and privilege
- embedding equity and belonging in every clinical, educational and leadership role
- holding ourselves accountable individually and collectively for making occupational therapy safe, accessible and meaningful for all.

1. Core concepts for inclusive practice

Why do core concepts matter in occupational therapy?

Meeting the Health and Care Professions Council (HCPC) Standard 5 requires more than following law and policy. Occupational therapists need shared values and approaches that guide day-to-day decisions. Three key concepts anti-oppressive practice, cultural humility and intersectionality provide that foundation.

Anti-oppressive practice

What is it?
Anti-oppressive practice means recognising and actively challenging the systems, structures and attitudes that create or reinforce inequality. It is not enough to be ‘non-discriminatory’ occupational therapists must take action to dismantle barriers.

In occupational therapy this means:

- questioning referral pathways, policies or practices that exclude people
- using a professional voice to advocate for fairer access to resources
- identifying subtle restrictions (e.g. blanket rules, inaccessible communication)

- supporting people to exercise choice and control in occupations that matter to them.

Practice example:

Scenario: An occupational therapist in adult social care notices the local housing adaptations policy excludes people in private rentals, disproportionately affecting disabled tenants with low incomes.

Response: The occupational therapist gathers evidence, challenges the policy through service leadership and works with housing officers to create an exceptions process.

Impact: More people gain access to adaptations, reducing health inequalities and promoting independent living.

Cultural humility

What is it?

Cultural humility is a commitment to self-reflection, openness and partnership. It recognises that no practitioner can ever be 'fully competent' in another person's culture, but every occupational therapist can approach with curiosity and respect.

In occupational therapy this means:

- asking, not assuming – let people define what is meaningful.
- acknowledging power differences in relationships
- being willing to adapt when mistakes are made
- valuing people's expertise in their own lives and identities.

Practice example:

Scenario: An occupational therapist is supporting a Sikh man who explains that faith-based practices are central to his wellbeing. Therapy activities clash with times for daily prayers.

Response: The occupational therapist adapts the timetable around prayer, works with him to design meaningful routines, and checks assumptions through ongoing dialogue.

Impact: The man feels respected and therapy supports rather than disrupts his spiritual life.

Intersectionality

What is it?

Intersectionality describes how multiple forms of disadvantage such as racism, ableism, classism, sexism or homophobia overlap and compound. It reminds occupational therapists that no-one experiences identity in isolation.

In occupational therapy this means:

- recognising that people may face compounded barriers
- avoiding one-size-fits-all interventions
- advocating for tailored, equitable support
- designing assessments and interventions that reflect real-life complexity.

Practice example:

Scenario: A young Black autistic woman is told she cannot join a local youth club due to assumptions about her communication.

Response: The occupational therapist challenges the exclusion, provides training on augmentative

and alternative communication and co-designs an adapted programme.

Impact: She participates fully and the youth club reviews its inclusion policy to welcome more neurodivergent young people.

Why do these concepts matter together?

Anti-oppressive practice, cultural humility and intersectionality are interconnected. Together they ensure occupational therapy is:

- reflective – aware of personal values, biases, and privileges
- relational – partnering with people as equals
- responsive – adapting to diverse needs and experiences
- rights-based – challenging the systems that perpetuate inequality.

Reflective question for occupational therapists:

How do I apply anti-oppressive practice, cultural humility, and intersectionality not only in individual sessions but also when influencing teams, services, and wider systems?

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2. Micro, meso and macro practice

Why is this important in occupational therapy?

Equity, diversity and belonging must be embedded at every level of occupational therapy practice. It is not enough to make changes only in one-to-one interactions. Occupational therapists have a role at the micro (individual), meso (team/service) and macro (system/policy) levels.

Micro level: Individual practice

In practice this means:

- delivering culturally responsive and anti-ableist care
- making reasonable adjustments and removing barriers to participation
- supporting communication preferences, gender identity and lived experience
- reflecting on personal biases and assumptions in assessments and interventions.

Practice example:

Scenario: An autistic adult is repeatedly offered group therapy despite stating they find groups overwhelming.

Response: The occupational therapist adapts the offer, creating a 1:1 pathway and co-producing goals with the person using visual support.

Impact: The person engages meaningfully in therapy, feeling respected and included.

Meso level: Team, service and local system

In practice this means:

- influencing workplace culture and clinical pathways
- challenging discriminatory policies or referral criteria

- advocating for equity in supervision, recruitment and placements
- supporting teams to embed inclusive practice.

Practice example:

Scenario: An occupational therapist recognises that a rehabilitation pathway excludes people with co-existing mental health needs.

Response: They bring this to the multidisciplinary team, gathering evidence and working with colleagues to redesign the pathway.

Impact: People with complex needs are no longer excluded, and the service becomes more equitable.

Macro level: Policy, strategy and systemic influence

In practice this means:

- contributing to consultations and professional guidance.
- advocating for legislative change to protect marginalised groups.
- embedding anti-racist, anti-ableist, and human-rights-based frameworks into national occupational therapy strategy.
- partnering with lived experience networks to shape inclusive systems.

Practice example:

Scenario: An occupational therapist joins a national advisory group on children's services. They notice that disabled children from racially minoritised communities are under-represented in data.

Response: They raise this gap, ensuring data collection and policy recommendations include intersectional considerations.

Impact: Policy changes are informed by more accurate data, leading to services that better reflect the diversity of children and families.

Why does working across all levels matter?

Change cannot happen only in individual sessions if services and systems remain inequitable.

Team and organisational policies shape whether inclusive practice is possible at the front line.

National strategies and legislation set the conditions in which occupational therapy operates.

Reflective question for occupational therapists:

At which level (micro, meso, macro) do I currently focus most of my energy, and how could I extend my influence across the others to embed equity and belonging more fully?

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3. Reflective practice and managing bias

Why is reflection important in occupational therapy?

Every occupational therapist brings their own values, beliefs and lived experience into practice. Reflection helps us recognise when biases or assumptions are influencing decisions and take action

to prevent discrimination or exclusion.

What do we mean by bias?

Conscious bias (explicit): Prejudice we are aware of (e.g. stereotyping or favouritism).
Unconscious bias (implicit): Hidden assumptions shaped by culture, upbringing or media.

Examples in occupational therapy:

Age bias: assuming older people cannot learn new skills.
Gender bias: assuming caregiving is 'women's work'.
Disability bias: underestimating or overestimating someone's capacity.
Cultural bias: privileging Western ideals of independence.
Confirmation bias: interpreting behaviour only through a diagnosis.
Affinity bias: connecting more easily with people 'like us'.

What are microaggressions?

Microaggressions are everyday comments or behaviours that communicate exclusion, even if unintended.

Examples include:

- Misgendering someone by refusing to use their pronouns.
- Saying, 'You speak such good English' to a UK-born colleague.
- Talking over neurodivergent or disabled colleagues.
- Stereotyping abilities ('You don't look disabled').

Key point: Microaggressions are never minor to the person experiencing them.

Reflective practice in action

Scenario: An occupational therapist realises they only ask pronouns when someone's gender expression appears 'non-conforming'.

Response: They change their practice to ask everyone consistently.

Impact: Assumptions are reduced and inclusivity normalised.

Practical tools:

- Journaling or audio reflections.
- Critical incident analysis.
- Bias checklists during assessments.
- Supervision as a safe reflective space.
- Feedback from colleagues and people with lived experience.

Reflective question:

When was the last time I recognised a bias in my practice, and how did I act on it?

4. Supporting colleagues and students

Why does this matter in occupational therapy?

Equity, diversity and belonging are not only about the people who access occupational therapy they also apply to how we support colleagues and students. Inclusive professional environments enable everyone to thrive and lead.

Supporting colleagues

- Create psychologically safe environments where identity can be expressed.
- Value lived experience as expertise.
- Challenge discrimination when it occurs.
- Ensure inclusive recruitment, supervision and appraisal processes.

Practice example:

Scenario: A newly qualified occupational therapist with a stammer is often interrupted in meetings.
Response: Their supervisor addresses the pattern with the team and reinforces respectful communication.
Impact: The therapist feels valued, and the team models more inclusive communication.

Supporting students

- Plan ahead for reasonable adjustments on placements.
- Offer multiple ways to demonstrate learning.
- Provide diverse role models.
- Use supervision to reflect on inclusion, not just clinical skills.

Practice example:

- **Scenario**: A student with ADHD struggles with written reflections.
- **Response**: The educator allows audio reflections and structured feedback sessions.
- **Impact**: The student demonstrates insight and grows in confidence.

Addressing marginalisation

Occupational therapists and students may face exclusion due to racism, ableism, LGBTQIA+ erasure, accent bias, classism or religious discrimination. These experiences affect confidence, opportunity and wellbeing.

Practice example:

Scenario: A Muslim occupational therapist describes racist overtones from colleagues being excluded from meetings, questioned about prayer breaks and treated differently during Ramadan.
Response: The supervisor validates the concerns, raises the issue with leadership as a systemic problem and ensures follow-up action.
Impact: The occupational therapist feels supported and wider cultural change begins.

Reflective question:

Do I create an environment where colleagues and students feel safe to be themselves, and do I act when barriers are raised?

5. Building inclusive services and teams

Why does this matter in occupational therapy?

Equity, diversity, and belonging (EDB) cannot be achieved by individuals alone. Services and teams need structures and cultures that embed inclusion.

Embedding inclusion in services

- Review policies for inclusivity.
- Conduct access audits.
- Collect and analyse data by protected characteristics.
- Co-produce services with lived experience.

Practice example:

Scenario: Few referrals are received from a local refugee community.
Response: The team co-designs outreach, translates materials and ensures interpreters are available.
Impact: Trust is built and referrals increase.

Embedding inclusion in teams

- Leadership must model anti-oppressive practice.
- Provide training in anti-racism, anti-ableism, LGBTQIA+ inclusion.
- Offer mentorship and sponsorship for underrepresented staff.
- Create psychologically safe environments.

Practice example:

Scenario: Disabled and racially minoritised staff are underrepresented in senior roles.
Response: Inclusive recruitment panels and mentoring schemes are introduced.
Impact: Leadership begins to reflect workforce diversity.

Reflective question:

What actions am I taking to build inclusion in my team or service, and how do I know they are making a difference?

Part 4: Embedding HCPC Standard 5

Why does this part matter?

The Health and Care Professions Council (HCPC) Standard of Proficiency 5 sets a clear expectation:
‘Registrants must recognise the impact of culture, equality and diversity on practice and be able to practise in a non-discriminatory, inclusive and respectful manner.’

For occupational therapists, this isn’t an optional extra – it’s a professional standard. Embedding Standard 5 requires more than awareness of equity, diversity and belonging (EDB); it requires proactive, reflective and rights-based practice.

How to use this section as an RCOT member

This part of the guidance is designed as a practical CPD tool. Each sub-section of Standard 5 includes:

- **core meaning in OT practice** – what the standard looks like day to day
- **practice examples** – real-world scenarios showing application in different contexts
- **affirmation in practice** – moving beyond compliance to active inclusion and belonging
- **reflection questions** – prompts for individual journaling, supervision, or peer discussion
- **CPD exercises** – short activities that can be used in:
- individual CPD (self-reflection, professional portfolio entries, HCPC re-registration evidence)
- supervision (to structure reflective conversations).
- **Team or service development** (group discussion, away days or in-service training)

RCOT members can:

- **use it for re-registration evidence**: record reflection questions and CPD exercises in your portfolio
- **integrate into supervision**: choose one sub-standard per session as a structured reflection tool
- **run group CPD sessions:** use the examples and questions as case studies for discussion
- **support student learning**: link placement supervision to real examples of inclusive practice
- **adapt for local training:** draw on the exercises to design workshops, away days or service reviews.

This section is intentionally interactive: it is not just ‘guidance’ but a resource to support your professional development, evidence your CPD and help you embed Standard 5 in practice.

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2. a. Embedding HCPC Standard 5.1: Recognising and responding to difference

HCPC Standard 5.1
‘Recognise the impact of differences such as protected characteristics, intersectional experiences and cultural differences on practice and be able to respond appropriately.’

Core meaning in occupational therapy practice
Recognising and responding to difference means seeing and valuing the whole person in all the complexity of their culture, identity, values, lived experiences and aspirations.

For occupational therapists this requires:

- acknowledging how health, wellbeing and systemic inequalities, affect access to, and participation in, occupations
- understanding that differences are not deficits but sources of identity, resilience and meaning
- moving beyond ‘awareness’ to actively affirm and celebrate diversity
- ensuring that each person’s identity is respected, supported and visible in the way services are delivered.

Refer back to:
- Why equity, diversity and belonging (Part 1)

- Intersectionality (Part 3)
- Cultural difference and occupational meaning (Part 3)

Practice examples

Example 1: Responding to intersectional experiences of racism and gender bias in pain management

Scenario: A Black woman in her forties is referred to occupational therapy within an NHS Pain Management Service after years of reporting severe musculoskeletal pain. She has repeatedly been told her symptoms are 'in her head' or attributed to stress. She works full-time in healthcare and is a family carer. By the time she reaches the service, she feels exhausted, unheard and sceptical.

Contextual fact: A 2022 BMJ survey found that 65% of Black people in the UK reported experiencing prejudice from NHS staff, rising to 75% among younger Black adults. This systemic disbelief including in relation to pain undermines trust and contributes to health inequities.

Response: The occupational therapist:

- begins with active listening and explicit validation, acknowledging the toll of repeatedly being disbelieved
- explores the impact of pain on her work, caring role, and identity without making assumptions
- adjusts the pace of assessment to build trust
- co-produces meaningful goals (e.g. returning to swimming, sustaining work routines) rather than focusing only on clinical outcomes
- reflects in supervision on racial and gender bias in pain management and advocates for bias-aware pathways in the wider team.

Affirmation in practice: The therapist explicitly acknowledges her expertise in her own body and history, affirming her resilience and her right to equitable, respectful, evidence-informed care.

Impact: She reports feeling 'heard for the first time', re-engages with rehabilitation and achieves her self-defined outcomes.

Linked guidance: See Part 3 – Intersectionality

Example 2: Adapting a functional assessment for a refugee with trauma history and language barriers

Scenario: A man in his thirties recently arrived in the UK as a refugee following conflict and displacement. Recovering from injuries and living in temporary housing, he speaks little English. No interpreter is provided at his initial assessment. Asked to perform tasks such as preparing food or managing medication, he appears anxious, avoids eye contact and gives minimal responses initially interpreted as low functional ability.

Contextual fact: An Equality and Human Rights Commission review (2018) found that 29% of people seeking or refused asylum were denied GP registration due to lack of paperwork despite their legal entitlement to NHS primary care. This highlights how administrative and systemic barriers undermine equity.

Rights to healthcare:

- recognised refugees are entitled to the same NHS care as UK residents
- people seeking asylum also have full access to NHS services while their claim is processed
- even refused asylum seekers remain entitled to urgent and immediately necessary treatment. ([BMA, NHS England])

Response – The occupational therapist:

- rearranges the session with a qualified interpreter
- contacts a local refugee support organisation to understand his cultural background and likely experiences of trauma
- adapts the assessment to include culturally relevant occupations
- builds rapport first, asking him how he defines independence and daily participation
- recognises the earlier session may have triggered a trauma response, not a lack of ability.

Affirmation in practice: The therapist validates the man's strengths and cultural knowledge, ensuring they shape the therapy plan rather than being overlooked.

Impact: In reassessment, he demonstrates far greater independence and confidence. He sets goals to rebuild daily routines and connect with local community and faith groups. The service adopts more culturally responsive assessment practices as a result.

Linked guidance: See Part 3 – Barriers to inclusion.

Example 3: Supporting a neurodivergent student on clinical placement

Scenario: A final-year occupational therapy student with ADHD is on placement in a large hospital. They struggle with time management in a noisy environment, and their confidence begins to fall. Without adjustments, they risk not meeting placement requirements despite strong clinical skills.

Contextual fact: A 2022 review of healthcare education found that there is no standardised system of support for neurodivergent students across UK clinical placements, leading to inconsistent or absent adjustments that place students at risk of disadvantage. (JMIRS, 2022)

Response: Together, the placement educator and student co-produce a support plan that includes:

- access to a quieter workspace for planning and documentation
- structured task lists with clear priorities
- visual time-management tools
- written as well as verbal feedback.

Affirmation in practice: The adjustments are not about compensating for deficits but enabling the student to demonstrate competence. Their neurodivergence is respected as part of who they are.

Impact: The student completes the placement successfully, meets learning outcomes and feels valued for both skills and individuality.

Linked guidance: See Part 3 – Reasonable adjustments in practice

Reflection Questions (5.1)

1. How do I actively affirm, not just 'tolerate' differences in the people I work with?
2. Which of my current cases, students or colleagues might benefit from approaches like those described above?
3. Have I considered how intersectional experiences are shaping participation or engagement?
4. Do my assessment tools, environments and communication methods reflect the diversity of the people I support?
5. How do I use supervision or peer reflection to recognise and challenge bias in my practice?

CPD exercise (5.1): Recognising and responding to difference

Select a recent case, student or colleague and reflect on the visible and less-visible identities that

shaped their participation (e.g. disability, ethnicity, gender, language, neurodivergence or caring responsibilities).

Identify the intersection of these identities and consider how they may have created barriers or opportunities.

Reflect on how you adapted your approach to support participation, or how you could have responded differently.

Link your reflections back to HCPC Standard 5.1 and relevant guidance such as intersectionality or culturally responsive practice.

Record your reflection in your CPD portfolio, available on the RCOT website as part of your membership. This supports you in meeting the HCPC's CPD standards.

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2. b. Embedding HCPC Standard 5.2: Applying equality, equity and inclusion legislation in practice

HCPC Standard 5.2

'Understand the importance of equality, equity and inclusion and apply legislation, policies and guidance relevant to their practice.'

Core meaning in occupational therapy practice

Occupational therapists hold both legal and professional responsibilities to ensure that every person they support can engage in the occupations that matter most to them. Participation in meaningful occupation is not only essential to health and wellbeing it is also a matter of human rights, dignity and belonging.

When people experience discrimination, systemic barriers or exclusion, their ability to participate in everyday life is reduced. Applying equality, equity and inclusion legislation is therefore more than a compliance task it is a fundamental part of ethical, person-centred occupational therapy.

Embedding this standard requires:

- a working knowledge of the Equality Act 2010, the Accessible Information Standard, the Care Act 2014, the Human Rights Act 1998 and other relevant frameworks
- anticipating barriers in advance and addressing them proactively
- ensuring that every stage of occupational therapy practice from assessment design to communication, environment and service pathways not only upholds legal rights but actively affirms identity and diversity.

Refer back to:

- Part 2: Equality Act and protected characteristics
- Part 2: Interacting legislation
- Part 5.4: Making and supporting reasonable adjustments

Practice examples

Example 1: Upholding the Equality Act in service access for a wheelchair user

Scenario: A person who uses a wheelchair is referred to a hospital outpatient hand therapy clinic following surgery. When they arrive, they discover the treatment room is only accessible via stairs with no lift available. The receptionist suggests they wait in the café and take written exercises home, effectively excluding them from direct therapy.

Contextual fact: The Equality Act 2010 places an anticipatory duty on health services to ensure reasonable adjustments are made in advance. Yet a 2021 Care Quality Commission review found that disabled people continue to face significant barriers to healthcare, including inaccessible premises and poor compliance with accessibility standards.

Response by the occupational therapist:

- recognises this as a breach of the Equality Act
- apologises and arranges an accessible treatment room immediately
- raises the issue with estates and facilities to ensure ongoing accessibility
- records the incident for organisational learning and reviews compliance procedures
- advocates for a full accessibility audit across outpatient therapy services.

Affirmation in practice: Accessibility is treated as a legal right, not an optional courtesy affirming the person's entitlement to equal participation.

Impact: The person re-engages fully in therapy and the service develops procedures to ensure all treatment rooms used for therapy are accessible.

Example 2: Embedding inclusive communication standards in learning disability services

Scenario: A person with a learning disability attends a clinic but receives pre-appointment instructions in complex written language. They arrive without the required paperwork, become distressed and face delays.

Contextual fact: The Accessible Information Standard (2016, NHS England) requires all NHS and publicly funded health and care providers to give information in accessible formats. Yet a 2022 NHS England audit found that only 56% of services consistently met the standard, leaving people with communication needs at risk of exclusion.

Response by the occupational therapist:

- applies the Accessible Information Standard and the **Human Rights Act 1998**provides easy read documents and offers to complete them together
- advocates for the service to adopt accessible formats as standard
- introduces communication needs alerts into patient records
- includes accessible communication in team continuing professional development (CPD) and works with the Equality and Diversity Lead to audit materials.

Affirmation in practice: Accessible communication becomes part of routine service delivery, not a 'special' measure.

Impact: The person engages more confidently and the service meets both legal and ethical duties.

Example 3: Challenging age discrimination in goal setting

Scenario: An older adult recovering from stroke expresses goals to return to driving, restart gardening and join a walking group. A colleague responds, 'At your age, maybe it's time to accept some limits' and focuses only on self-care.

Contextual fact: The Care Act 2014 and NICE stroke rehabilitation guidelines emphasise personalised, goal-oriented rehabilitation at all ages. Yet research by Age UK (2021) found that older adults in England are less likely to be offered post-stroke rehabilitation than younger patients reflecting systemic age bias.

Response by the occupational therapist:

- validates the individual's ambitions and co-produces safe, realistic steps
- raises the age-based comment in supervision as an example of unconscious bias
- advocates for co-produced goals in Multidisciplinary Team (MDT) meetings
- cites NICE and Care Act 2014 guidance to support personalised rehabilitation
- documents goals in terms of meaningful occupation and identity.

Affirmation in practice: Age is not treated as a barrier to meaningful participation. Aspirations are respected, not dismissed.

Impact: The person feels valued and motivated and the MDT gains insight into how age bias can limit opportunities.

Reflection Questions (5.2)

1. How do I ensure I am applying equality legislation in every stage of occupational therapy practice?
2. Do I anticipate and address barriers before they impact the person?
3. How do I adapt communication so it is accessible to all?
4. When using standardised pathways, how do I ensure flexibility to protect rights and meet individual needs?
5. Am I confident in recognising when someone's legal rights are at risk in the therapy process?

CPD exercise (5.2): Applying Equality, Equity, and Inclusion Legislation

Choose a recent case or service example where equality or inclusion legislation was relevant.

Identify the specific legislation, policy or guidance that applied (e.g. Equality Act 2010, Accessible Information Standard).

Reflect on how you applied, or could have applied, the legislation in assessment, planning or service delivery.

Consider the potential consequences if the legislation had not been applied, particularly in relation to rights, safety or participation.

Record your reflection in your CPD portfolio, available on the RCOT website as part of your membership. This supports you in meeting the HCPC's CPD standards.

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2. c. Embedding HCPC Standard 5.3: Understanding and addressing personal values, beliefs and bias

HCPC Standard 5.3

'Recognise the potential impact of own values, beliefs and personal biases (which may be unconscious) on practice and take action to ensure all service users and carers are treated appropriately and with respect and dignity.'

Core meaning in occupational therapy practice

Every occupational therapist brings their own values, beliefs and lived experiences to practice. These are shaped by culture, upbringing, education, religion or spirituality, professional training and personal life events. They influence how situations are interpreted, how decisions are made and how relationships are formed with those accessing services.

When consciously examined, these influences can strengthen empathy, ethical reasoning and connection. When unexamined, particularly where unconscious bias is involved, they may narrow the scope of therapeutic options and unintentionally exclude or disadvantage people.

Meeting HCPC Standard 5.3 requires more than acknowledging difference. It calls for sustained self-reflection, openness to cultural humility (see Part 3: Core Concepts – Cultural humility) and a willingness to practise anti-oppressive approaches (see Part 3: Core Concepts – Anti-oppressive practice). This ensures therapy respects each person's identity, affirms their experiences and enables participation in the occupations that are most meaningful to them.

For more on identifying and addressing structural bias, see:

- Part 5.5: Recognising barriers to inclusion
- Part 5.6: Challenging barriers and leading change

Understanding values, beliefs and bias

- **Values** are deeply held principles about what is right, fair or important. They influence how priorities are set and how "good" outcomes are defined.
- **Beliefs** are personal perspectives about ourselves, others and the world, shaped by culture, religion, education and lived experience.
- **Biases** are tendencies, often unconscious, that affect how people are perceived, judged or responded to. Bias can be:
- explicit (conscious) – deliberate preferences or prejudices.
- implicit (unconscious) – automatic associations that influence decisions without awareness.

Both explicit and implicit bias can undermine fairness and dignity in occupational therapy if left unchallenged.

Practice examples

Example 1: Working with a non-binary person

Scenario: A young adult who identifies as non-binary is accessing occupational therapy for fatigue management. The therapist, without deliberate reflection, uses gendered language such as 'she' and 'young woman' in conversation and documentation. Over time, the person disengages and begins cancelling appointments.

Contextual fact: Research by Stonewall (2018) found that one in seven LGBTQIA+ people avoid healthcare services for fear of discrimination. Misgendering and the use of non-affirming language are common barriers to engagement for non-binary people in the UK.

Response by the occupational therapist:

- in supervision, the therapist reflects on how assumptions about gender shaped communication
- they update records with the correct name and pronouns
- attend CPD on inclusive language and LGBTQIA+ affirming practice (see Part 1: Affirmation in Practice)
- apologise and re-establish contact, giving space for the person to define how they wish to proceed
- advocate for service-wide documentation templates free of unnecessary gendered language.

Affirmation in practice:
The therapist's actions affirm identity, rebuild trust and create a therapeutic environment where participation feels safe and respectful.

Example 2: Recognising bias when assessing for equipment in a hoarded environment

Scenario: An occupational therapist visits a person's home to assess for a stairlift and bathing equipment after hospital discharge. The home is heavily cluttered with narrow walkways. The person refuses support for cleaning, decluttering or mental health referral. The therapist feels frustration, noticing a pull toward judging the state of the home rather than focusing on the person's occupational goals.

Contextual fact: A 2019 review by Public Health England estimated that hoarding disorder affects 2–5% of the population. People who hoard often face stigma in health and social care with professionals reporting discomfort or avoidance, which can compromise equitable access to services.

Response by the occupational therapist:

- the therapist pauses and recognises personal values around cleanliness are influencing judgment
- reframes the assessment to focus on safety and function, not personal standards
- uses neutral, factual language in documentation rather than stigmatising terms
- explores the reaction further in supervision to prevent bias clouding decisions.

Affirmation in practice: By respecting the person's autonomy and priorities, the therapist supports their right to define what 'home' means while still addressing safety and function.

Example 3: Recognising and challenging bias during recruitment

Scenario: While shortlisting for an occupational therapy assistant role, the panel reviews applications, including one from a candidate with qualifications gained at a Nigerian university. A colleague questions whether these are 'equivalent' and speculates about 'cultural barriers' or 'language issues', despite no evidence of this in the application.

Contextual fact: The NHS Workforce Race Equality Standard (WRES) 2023 reports that Black and minority ethnic applicants are 1.54 times less likely to be appointed from shortlisting compared with White applicants. Candidates with international qualifications, particularly from African universities, often face additional scrutiny and stereotyping, which reflects systemic racial bias in recruitment.

Response by the occupational therapist:

- the occupational therapist challenges the assumptions and reminds the panel that decisions must align with the person specification and essential criteria
- recommends verifying the validity of international qualifications through recognised accreditation processes rather than assuming inadequacy
- raises concerns with Human Resources and suggests targeted equality, diversity and inclusion training for recruiting managers (see Part 3: Building inclusive services and teams).

Affirmation in practice: By challenging unsupported assumptions, the therapist ensures all candidates including those educated outside the UK receive fair and equal consideration. This affirms the value of diversity in strengthening services and addresses bias that disproportionately affects Black applicants.

Reflection questions (5.3)

1. When did my own values or beliefs last influence a decision and how did I respond?
2. How do I ensure my cultural or professional norms do not override those of the people I work with?

3. Do I invite feedback from the people I support about whether they feel respected and included?
4. Does my team create safe space for discussion about bias, identity and difference?
5. What steps am I taking to actively build cultural humility and anti-oppressive practice skills?

CPD exercise (5.3): Understanding and addressing personal values, beliefs and bias

Recall a time when your own values or beliefs influenced your practice, either positively or negatively.

Reflect on the impact of this influence on the person, student, or colleague involved.

Identify whether unconscious bias may have played a role and consider how it shaped your decisions.

Explore how you could have responded differently, drawing on cultural humility or anti-oppressive practice.

Record your reflection in your CPD portfolio, available on the RCOT website as part of your membership. This supports you in meeting the HCPC's CPD standards.

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2. d. Embedding HCPC Standard 5.4: Making and supporting reasonable adjustments

HCPC Standard 5.4

'Understand the duty to make reasonable adjustments in practice and be able to make and support reasonable adjustments in their and others' practice.'

Core meaning in occupational therapy practice

Occupational therapists have a legal, ethical, and professional responsibility to ensure all people can access occupational therapy without facing unnecessary barriers. The duty to make reasonable adjustments is a statutory right under the Equality Act 2010 (and the Disability Discrimination Act 1995 in Northern Ireland).

Reasonable adjustments are designed to remove or reduce the disadvantage experienced by disabled and neurodivergent people when accessing services, education or employment. In occupational therapy, this means creating conditions where people can fully participate in the occupations that matter to them – whether showering, getting dressed, parenting, working, studying or engaging in leisure and social life.

Making reasonable adjustments involves:

- designing therapy environments and communications to be accessible from the outset
- adapting assessments and interventions to meet individual needs and preferences
- supporting students and colleagues to access and thrive in education or employment
- challenging ableist assumptions and embedding inclusion by design.

Refer back to:

- Part 2: Reasonable adjustments vs clinical interventions
- Part 3: Reasonable adjustments in practice
- Part 3: Supporting colleagues and students

Practice examples

Example 1: Reasonable adjustment for a person accessing occupational therapy

Scenario: A person living with chronic fatigue syndrome is referred for an occupational therapy assessment. Their energy levels vary day to day, and they experience significant cognitive fatigue, particularly in noisy, busy environments. Previous appointments have left them drained and unable to engage, resulting in incomplete assessments and frustration.

Contextual fact: Research by Action for ME (2022) found that over 70% of people with chronic fatigue syndrome/myalgic encephalomyelitis felt their needs were not met in healthcare settings, often due to environments and processes that ignored energy limitations.

Response by the occupational therapist:

- discusses preferred appointment times, learning that mornings are best
- books a quiet, low-stimulation room to reduce sensory demands
- splits the assessment into two shorter sessions
- provides written prompts and key points to reduce reliance on memory.

Affirmation in practice: These changes affirm the person's right to access care in a way that honours their energy patterns and cognitive needs. The adjustments are presented as equitable practice, not special favours.

Impact: The person participates fully, providing accurate information without becoming overwhelmed. The adaptations ensure equal access to the assessment itself.

Example 2: Reasonable adjustment for a mature occupational therapy student on a prison placement

Scenario: A mature occupational therapy student with arthritis begins a placement in a prison healthcare service. The role involves long walks across the large site, climbing multiple flights of stairs in older prison wings, and attending lengthy multidisciplinary team (MDT) meetings that require prolonged sitting. Within the first week, the student experiences significant joint pain and fatigue, which make it difficult to participate fully in learning opportunities and risk affecting placement outcomes.

Contextual fact: The **Council of Deans of Health (2021)** found that healthcare students with long-term health conditions frequently report difficulty securing and receiving timely adjustments on placement, leading to unnecessary disadvantage. Prison placements add additional challenges due to strict routines, demanding environments and long meetings where flexibility is often limited.

Response by the occupational therapist:

- the placement educator meets with the student to identify barriers
- adjustments are agreed, including access to a ground-floor base room, permission to use lifts where available, and flexibility to take stretch breaks during long MDT meetings
- walking-intensive tasks are scheduled with peer or educator support to reduce physical strain
- regular check-ins are arranged to monitor effectiveness of adjustments and ensure the student is not excluded from key learning experiences.

Affirmation in practice: The adjustments are framed as enabling equitable access to professional learning, not as reducing expectations. The student's health needs are respected as part of their identity and capacity to train as a future occupational therapist.

Impact: The student successfully completes the placement, demonstrates required competencies, and reports feeling supported and included. The prison healthcare team gains insight into how simple, low-cost adjustments can enable wider participation in challenging environments.

Example 3: Reasonable adjustment for an employed occupational therapist with Long Covid

Scenario: An experienced occupational therapist develops Long Covid after a severe infection. They experience fluctuating fatigue, breathlessness and cognitive difficulties (brain fog), which make prolonged meetings, back-to-back appointments and extended computer work extremely challenging. Without adjustments, they risk reduced performance, sickness absence or leaving their role.

Contextual fact: The Office for National Statistics (2023) estimated that 1.9 million people in the UK were living with Long Covid, with fatigue and cognitive difficulties the most common symptoms. A TUC survey (2022) found that one in seven workers with Long Covid had lost their job, often due to lack of workplace adjustments.

Response by the occupational therapist:

- the manager meets with the therapist to explore barriers
- agrees on flexible working hours, including options for remote working on high-fatigue days
- introduces adjustments such as shorter meetings with regular breaks, reduced caseload intensity, and voice-to-text software to reduce cognitive and physical strain
- provides access to occupational health and encourages pacing strategies consistent with National Institute for Health and Care Excellence (NICE) Long COVID guidance.

Affirmation in practice: These adjustments are framed as a legal right under the Equality Act 2010, recognising long COVID as a condition that can meet the Act's definition of disability. They affirm the therapist's right to remain in employment without disadvantage.

Impact: The occupational therapist maintains their role, contributing meaningfully while managing their health. Their experience also raises awareness within the team, helping embed a culture of flexibility and inclusion for colleagues with fluctuating conditions.

Reflection questions (5.4)

1. How confident am I in distinguishing between a reasonable adjustment and a clinical intervention?
2. Do I treat adjustments as a legal right, or as something negotiable?
3. How do I anticipate and remove barriers before they arise?
4. What is my response when standard processes disadvantage disabled or neurodivergent people?
5. Have I embedded common adjustments into everyday practice in my setting and supported colleagues and students to do the same?

CPD exercise (5.4): Making and supporting reasonable adjustments

Select a person, student or colleague who required reasonable adjustments.

Reflect on the adjustments that were (or weren't) made and how these supported or limited participation.

Consider whether the adjustments were framed as rights under equality legislation or as optional 'allowances'.

Identify one adjustment that could have been embedded into everyday practice to prevent barriers from arising.

Record your reflection in your CPD portfolio, available on the RCOT website as part of your membership. This supports you in meeting the HCPC's CPD standards.

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2. e. Embedding HCPC Standard 5.5: Recognising barriers to inclusion

HCPC Standard 5.5

‘Recognise the characteristics and consequences of barriers to inclusion, including for socially isolated groups.’

Core meaning in occupational therapy practice

Inclusion is not achieved by simply making services available – it is achieved when all barriers that prevent meaningful participation are identified, challenged and removed. These barriers may be physical, procedural, cultural, sensory, systemic or attitudinal, and they are often invisible to those who are not directly affected by them.

Occupational therapists have a professional and ethical responsibility to recognise these barriers and act on them. Without this awareness, well-intentioned services risk reinforcing the very exclusions they aim to address**.**

Meeting this standard means being proactive by:

- seeking out the less obvious reasons why someone might disengage
- recognising that non-attendance or lack of motivation can be a symptom of an inaccessible system
- understanding how intersecting identities such as race, disability, gender, poverty, or caring responsibilities amplify exclusion.

Refer back to:

- Part 3: Recognising and tackling barriers to inclusion
- Part 3: Intersectionality
- Part 3: Culturally responsive practice

Practice examples

Example 1: Procedural and social barrier – child and single parent in a school setting

Scenario: A child with Developmental Coordination Disorder (DCD), also known as dyspraxia, is referred to school-based occupational therapy. Their single parent is eager to engage but struggles to attend mid-morning school meetings due to work and childcare for younger siblings. After two missed sessions, school staff suggest the parent is ‘not committed’ and question whether therapy should continue.

Contextual fact: The Children’s Commissioner for England (2021) reported that children of single parents are more likely to experience barriers in accessing health and education support, particularly when rigid appointment systems do not account for caring responsibilities and economic pressures.

Response by the occupational therapist:

- contacts the parent directly and learns about the challenges of scheduling
- offers flexible options, including after-school sessions, video calls and written updates for the parent
- works with the school to provide therapy sessions during class time, reducing reliance on parental attendance
- records caregiving demands as a contextual barrier rather than misrepresenting them as disengagement.

Affirmation in practice: By adapting processes to fit the family's circumstances, the occupational therapist affirms that inclusion must take account of both the child's needs and the parent's essential caregiving role.

Impact: The child remains engaged in therapy, makes progress on fine motor and participation goals, and the parent feels respected and supported rather than penalised. The school begins reviewing parent communication systems to better accommodate diverse family structures.

Example 2: Cultural barrier – Assessment task not aligned with person's background

Scenario: An older South Asian man is referred to occupational therapy after a stroke. The therapist uses a standardised kitchen task – making tea and toast – to assess functional and cognitive skills. Although he completes the task, he appears disengaged and later declines further sessions, saying the therapy 'doesn't seem relevant'.

Contextual fact: Research on culturally responsive care in the NHS (King's Fund, 2022) shows that ethnic minority patients are more likely to disengage when services fail to reflect cultural and occupational relevance, reinforcing exclusion even when care is technically available.

Response by the occupational therapist:

- in supervision, reflects on the mismatch between the task and the person's background
- learns that valued occupations included attending mosque, community organising and gardening
- adapts therapy to focus on improving mobility to access the mosque and skills needed for gardening
- incorporates a discussion of meaningful occupations into all assessments going forward.

Affirmation in practice: By tailoring therapy to culturally relevant roles, the occupational therapist affirms that meaningful recovery must reflect each person's lived reality, not a one-size-fits-all model.

Impact: The man re-engages, progresses in therapy, and resumes valued occupations. The team becomes more aware of culturally responsive assessment practices.

Example 3: Systemic and cultural barrier – supporting a young woman from a traveller community in social care

Scenario: A young woman from a Traveller background is referred to social care occupational therapy for long-term disability support following a road traffic accident. Before arranging a visit, the occupational therapist sends a standard appointment letter that assumes she lives in a permanent house and lists potential adaptations such as stair rails, grab bars and bathroom modifications. On receiving the letter, the young woman feels misunderstood and excluded her family lives in a trailer on private land, and such fixed adaptations are irrelevant to her lifestyle. Feeling the service will not meet her needs, she disengages and does not respond to the appointment letter.

Contextual fact: The NHS Inclusion Health Framework (2023) identifies Gypsy, Roma and Traveller communities as among the most disadvantaged groups, facing severe exclusion and poorer experiences of health and social care compared to the wider population.

Response by the occupational therapist:

- reflects on the disengagement and reviews the language and assumptions in the standard letter
- seeks guidance from a Traveller advocacy organisation and the local authority's equality lead to understand better ways of communicating

- re-contacts the young woman by phone, apologises for the assumptions in the letter and arranges a face-to-face visit
- during the visit, engages in a culturally respectful conversation about her valued occupations, daily routines and long-term goals
- identifies portable and flexible equipment solutions such as lightweight ramps, mobile shower equipment, and adapted cooking tools that fit her home environment and mobile lifestyle
- raises the issue of standard letters in team meetings, advocating for a review so communications reflect diversity in housing and living situations.

Affirmation in practice: By acknowledging the error and adapting both communication and intervention, the occupational therapist affirms the young woman's cultural identity and right to equitable, relevant occupational therapy.

Impact: The young woman receives appropriate portable equipment that supports her independence and participation in family and community life. The team becomes more aware of how standardised processes can unintentionally exclude people, leading to a review of communications to ensure they are inclusive and flexible.

Reflection Questions (5.5)

1. What environmental, sensory, procedural, cultural or attitudinal barriers might be limiting inclusion for the people I work with?
2. How do I distinguish between 'non-engagement' and responses to inaccessible services?
3. Do my records use inclusive, strengths-based language, or do they unintentionally frame people through deficits?
4. What assumptions do I hold about how people 'should' participate in therapy and who might be excluded by these?
5. What actions do I take when I see exclusion or misrepresentation happening in my service?

CPD exercise (5.5): Recognising Barriers to Inclusion

Review a recent case, student or colleague where participation was reduced or 'non-engagement' was noted.

List all potential barriers (environmental, sensory, procedural, cultural or attitudinal) that may have contributed.

Reflect on how these barriers were recorded as inclusion issues or as personal deficits.

Identify one change or adjustment that could reduce the barrier and improve participation.

Record your reflection in your CPD portfolio, available on the RCOT website as part of your membership. This supports you in meeting the HCPC's CPD standards.

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2. f. Embedding HCPC Standard 5.6: Challenging barriers and leading change

HCPC Standard 5.6

'Actively challenge these barriers, supporting the implementation of change wherever possible.'

Core meaning in occupational therapy practice

Occupational therapists are expected not only to identify barriers to participation (as set out in

Standard 5.5) but also to take purposeful, sustained action to address and remove them.

Challenging exclusion is not a personal preference or an optional extra – it's a professional duty grounded in equity, rights-based practice and occupational justice.

Barriers to inclusion whether environmental, procedural, cultural, attitudinal or systemic often persist because they are accepted as 'normal'. Left unchallenged, they continue to exclude disabled people, neurodivergent people, people from racially minoritised communities and others who experience marginalisation. Silence or passive compliance allows these barriers to remain.

Occupational therapists are uniquely placed to lead change through their expertise in participation, occupation and environmental design. This leadership includes advocating for, co-producing and embedding changes that make it possible for people to engage fully and meaningfully in the occupations that matter to them.

Challenging vs. complying

Complying with inclusion policies is not enough. Challenging exclusion means:

- noticing where policies or practices are not working in reality
- being prepared to question them constructively
- recording unmet needs so they are visible and cannot be erased
- offering evidence-based alternatives to exclusionary practices
- working with those affected to co-create sustainable solutions
- following up to ensure changes are implemented, not just discussed.

Key reflective question:
Who is being left out of this service, this space, this conversation or this pathway and what needs to change?

Supporting implementation of change

Challenging exclusion is only the first step. Supporting change means helping to make it happen and ensuring it lasts.

This may involve adapting everyday practice, influencing team culture, or contributing to service-wide and policy-level improvements. Wherever the focus lies, effective change should always be:

- documented – patterns are recorded, not just isolated incidents
- co-produced – designed with those directly affected, not for them
- evidence-based – backed by practical, tested solutions
- sustained – followed up and reviewed over time.

Refer back to

Standard 5.5: Recognising barriers to inclusion
Standard 5.4: Making and supporting reasonable adjustments

Practice examples

Example 1: Challenging a blanket restriction in a mental health setting

Scenario: An occupational therapist on an adult mental health ward learns about a policy preventing all people from accessing the outdoor garden after 4pm, regardless of need or risk, due to 'staffing levels'. People explain that this restriction limits opportunities for prayer, self-regulation and fresh air.

Response by the occupational therapist:

- raises the issue in the multi-disciplinary team (MDT) meeting, identifying it as a blanket restriction not based on individual assessment
- works with nursing and psychology colleagues to co-produce individual access plans and staff rotas, informed by feedback from people accessing the service
- references Care Quality Commission (CQC) guidance on reducing restrictive practices to strengthen the case.

Impact: People are now able to access the garden in the evenings, improving wellbeing and sleep. The ward begins reviewing other restrictions using the same inclusive approach.

Example 2: Challenging the use of unexplained acronyms in workplace communication

Scenario: A dyslexic, occupational therapist notices that meetings and emails are filled with unexplained acronyms, making it hard to follow discussions. This is mentally exhausting, exclusionary and undermines confidence. They have tried to address this within a team meeting and supervision but others continue to say and write unexplained acronyms and roll their eyes when the occupational therapist repeated how difficult they are for them to follow and remember. They are made to feel incompetent, isolated and different from others.

Response by the occupational therapist:

- raises the issue in team meetings and explains its impact in supervision
- writes a blog for the Trust Chief Executive describing how acronym-heavy communication disadvantages neurodivergent staff, people with learning disabilities and those unfamiliar with healthcare jargon
- collaborates with the equality, diversity and inclusion team to create resources and propose a plain language policy.

Impact: The Trust commits to reducing unexplained acronyms in written and spoken communications and adds a plain language standard to induction training, benefiting staff and people accessing services alike.

Example 3: Recognising financial barriers to occupational therapy engagement

Scenario: A community occupational therapist receives a referral for a person struggling to re-establish routines after housing instability. Clinic sessions are arranged, but the person repeatedly cancels. During a home visit, the therapist learns they live in temporary accommodation without heating, cooking facilities or transport.

Contextual fact: Research from the King's Fund highlights that people living in the most deprived areas of England are nearly twice as likely to attend A&E due to difficulties accessing timely GP appointments. Poverty and housing instability therefore create structural barriers that undermine access to healthcare, even though services are free at the point of use (The King's Fund, 2020).

Response by the occupational therapist:

- reframes therapeutic goals to address immediate needs such as accessing food banks and rebuilding small self-care routines
- delivers sessions via outreach or community hubs to remove travel and financial barriers
- advocates within housing and social care systems to highlight the impact of poverty on occupational participation
- raises awareness with the team about how financial hardship shapes engagement.

Impact: The person begins engaging more consistently and the service develops more flexible, compassionate approaches for supporting people facing economic hardship.

Reflection questions (5.6)

1. When I see a barrier to inclusion, do I act, avoid or delay, and why?
2. How confident am I in challenging organisational norms that disadvantage certain people?
3. What strategies do I use to raise concerns about inequality or access, and do I feel supported to speak up?
4. How do I ensure that the changes I help create are co-produced and sustained, not reliant on one advocate?
5. Is inclusion something I embed daily, or only address when prompted?

CPD exercise (5.6): Challenging barriers and leading change

Think of a time you observed a barrier to inclusion within your service or workplace.

Reflect on how you responded did you act, avoid, or delay and why?

Reframe the situation and identify specific actions you could have taken to challenge the barrier constructively.

Identify one step you can take now to strengthen your confidence in raising or addressing barriers in your setting.

Record your reflection in your CPD portfolio, available on the RCOT website as part of your membership. This supports you in meeting the HCPC's CPD standards.

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2. g. Embedding HCPC Standard 5.7: Leadership and accountability for inclusive practice

HCPC Standard 5.7

'Be able to take responsibility for ensuring that their practice is inclusive, and to support others to do the same'.

Core meaning in occupational therapy practice

Standard 5.7 emphasises that inclusive practice is not only about what each occupational therapist does individually, but also about how they contribute to a culture of accountability across services.

Occupational therapists are expected to take responsibility for their own practice and to use their influence to support colleagues, students and teams in embedding inclusion.

This requires visible leadership, whether at the level of supervising a student, leading a service, project, or team, working as part of a multi-disciplinary team (MDT), or shaping organisational policy. Inclusive practice must be modelled, championed and supported at every level, so that it becomes the norm rather than the exception.

Taking responsibility means:

- reflecting honestly on the inclusivity of your own practice
- supporting colleagues and students when they raise issues of equity, diversity or belonging
- acting to address exclusionary practices in teams or services
- embedding accountability into governance, supervision and service planning.

Refer back to:

- Part 1: Affirmation in practice
- Part 3: Building inclusive services and teams
- Section 5.3: Understanding and addressing personal values, beliefs and bias
- Section 5.5: Recognising barriers to inclusion
- Section 5.6: Challenging barriers and leading change

Practice examples

Example 1: Occupational therapist challenging stereotypes in a charity setting

Scenario: An occupational therapist begins working for a charity that supports people with profound and multiple learning disabilities (PMLD). They observe that most of the activities offered are limited, repetitive and based on stereotypes of what people 'can manage'. Opportunities are restricted mainly to passive activities inside the charity's base, with little chance for individuals to participate in wider community life.

Note on terminology: The term profound and multiple learning disabilities (PMLD) is the one most commonly used in NHS and healthcare documentation to refer to people with significant learning disabilities alongside additional physical, sensory or health needs. However, many families and some disabled people prefer the term complex disabilities, as it is seen as less medicalised and more reflective of the person as a whole, rather than emphasising impairment. Both terms are in use and occupational therapists should be responsive to the language preferred by individuals and families.

Contextual fact: Research from Public Health England has shown that people with PMLD are among the most excluded groups in society, with extremely limited access to community activities and high levels of social isolation (Public Health England, 2016).

Response by the occupational therapist:

- raises concerns with staff about how limiting assumptions reduce opportunities for meaningful occupation
- works alongside the team to explore each person's interests, preferences and strengths
- co-designs new opportunities that extend beyond the centre, including community participation
- supports staff to understand the rights of people with PMLD/complex disabilities to access varied and fulfilling occupations
- advocates for better transport arrangements and accessible community partnerships to widen opportunities.

Impact: People supported by the charity begin to access more meaningful activities, including trips into the community, creative projects, and sensory experiences tailored to their goals. Staff develop greater confidence in supporting choice and participation, and the organisation begins to shift its culture from providing 'safe activities' to enabling genuine engagement in everyday life.

Example 2: Head of occupational therapy planning an inclusive conference

Scenario: The Head of Occupational Therapy in an NHS Trust is responsible for planning the annual occupational therapy staff conference at a venue outside the Trust. Feedback from the previous year highlighted serious accessibility issues: the chosen venue was not accessible for one occupational therapist who uses a wheelchair, caused significant difficulties for staff who are neurodivergent due to overwhelming noise and lighting and created barriers for a staff member who is deaf and uses a cochlear implant because of poor acoustics and lack of hearing loop provision.

Contextual fact: NHS England guidance on accessible communications and events emphasises that staff with disabilities are often excluded from professional development opportunities when accessibility is not prioritised, undermining equality of opportunity in career progression (NHS England, 2022).

Response by the occupational therapist:

- works with the Trust's equality, diversity, and inclusion team to develop an accessibility checklist for venues
- consults the staff who were affected the previous year to ensure their feedback directly shapes planning
- co-creates the event, considering both the physical accessibility of the venue and the content and flow of the day
- builds in measures such as quieter networking options, breaks to reduce fatigue and accessible presentation formats
- eaccessibility requirements (e.g. hearing support technology, quiet spaces, accessible toilets) are written into the venue contract as non-negotiable.

Impact: The next conference is significantly more inclusive, with staff reporting improved participation and belonging. The co-production process strengthens trust, and the accessibility checklist is adopted Trust-wide for all staff events, raising organisational standards.

Example 3: Occupational therapist advocating for inclusive practice in an eating disorder service

Scenario: An occupational therapist working in an NHS eating disorder service notices that the therapeutic programme is heavily focused on talking therapies and weight monitoring, with limited attention to occupation, daily routines and meaningful activity. Several people accessing the service have expressed frustration that their recovery is defined only by medical or clinical markers, rather than by their ability to return to valued occupations such as cooking with family, studying or socialising.

Contextual fact: The Royal College of Psychiatrists (2021) highlighted that recovery in eating disorders is often narrowly defined by weight or BMI, and called for services to adopt more holistic, person-centred approaches that include social and occupational outcomes.

Response by the occupational therapist:

- raises the gap in provision within the multi-disciplinary team (MDT), highlighting the role of occupation in recovery
- works with people accessing the service to co-produce occupation-focused goals
- designs interventions such as meal preparation, sensory regulation strategies and community participation planning
- advocates at service planning meetings for occupational therapy to be embedded more centrally within the care pathway
- promotes the view that recovery must be defined by participation in meaningful occupations, not weight alone.

Impact: The service begins to incorporate occupation-focused interventions into treatment plans, giving people more choice in how recovery is defined and supported. Staff across the MDT gain a greater understanding of the role of occupation in eating disorder recovery, and the voices of people with lived experience become more central to service development.

Reflection questions (5.7)

1. How do I demonstrate accountability for inclusion in my daily practice?
2. Do I encourage and support colleagues and students to raise issues of equity, diversity and

belonging?
3. When I am in a leadership position, how do I ensure inclusion is embedded in planning, decision-making, and service delivery?
4. Do I treat feedback about accessibility or inclusion as a learning opportunity, or as criticism?
5. How do I model inclusive practice in the way I supervise, manage or lead others?

CPD exercise (5.7): Leadership and accountability for inclusive practice

Select a leadership experience (e.g. supervising, leading a project, managing a service or planning an event).

Reflect on how inclusion and accessibility were addressed in your planning and decision-making.

Consider whose voices were included or missed and what impact that had on outcomes.

Reflect on how you responded to feedback: Did you treat it as a learning opportunity or as criticism?

Record your reflection in your CPD portfolio, available on the RCOT website as part of your membership. This supports you in meeting the HCPC's CPD standards.

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Part 5: Glossary of terms and acronyms (A–Z)

Ableism
Discrimination or systemic bias against disabled people, based on the assumption that non-disabled ways of living are superior.

Accessible Information Standard (AIS)
A legal duty in England requiring NHS and adult social care services to provide information in accessible formats for people with disabilities, impairments or sensory loss.

Allyship
Active support for marginalised groups through advocacy, solidarity and challenging discrimination.

Anti-oppressive practice
Approaches that identify and challenge unfair systems, policies or attitudes that exclude or harm people.

Belonging
The sense of being accepted, valued and safe within a group or environment.

Bias
Assumptions or preferences, conscious or unconscious, that influence judgement, behaviour and decision-making.

Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME)
A long-term condition causing severe fatigue, pain, cognitive difficulties and other symptoms. Impact varies and may require specific adjustments.

Co-creation
A collaborative process where people with lived experience and professionals shape services, resources or ideas together from the earliest stage.

Co-design

A structured design approach where people with lived experience and professionals work together to create solutions that reflect lived perspectives and practical needs.

Co-production
A partnership where power and responsibility are shared equally between people with lived experience and professionals in planning, delivery and evaluation.

Continuing Professional Development (CPD)
Ongoing learning to maintain, improve, and broaden professional knowledge and practice.

Cultural humility
A lifelong commitment to reflection and openness, recognising power imbalances and respecting different cultural perspectives.

Cultural responsiveness
The ability to adapt practice to respect and reflect people's cultural values, beliefs and traditions.

Disability
Defined in the Equality Act 2010 as a physical or mental impairment with substantial and long-term adverse effects on daily life.

- Medical model: Locates disability in the individual and focuses on deficits.
- Social model: Locates disability in societal barriers (e.g. inaccessible environments, discrimination). This aligns with occupational therapy values.

Disability bias
Prejudice or assumptions about a person's abilities or limitations based on disability.

Disabled person/Non-disabled person
Preferred UK terms that align with the social model of disability. These avoid ableist alternatives such as 'able-bodied' or 'normal'.

Discrimination
Unfair treatment of people because of identity or characteristics; can be direct, indirect, systemic or institutional.

EDI (Equality, Diversity and Inclusion)
Term used by HCPC. Focuses on recognising difference, removing barriers and practising in a fair, inclusive way.

EDB (Equity, Diversity, and Belonging)
Term used by RCOT. Goes beyond EDI by emphasising equity (fairness according to need) and belonging (psychological safety and inclusion).

Equality
Treating people the same.

Equity
Providing support tailored to individual barriers and needs to achieve fairness.

Human rights-based practice
Approaches grounded in legal rights such as dignity, privacy, liberty and equality.

Identity-first and person-first language
Identity-first (e.g. disabled person) affirms disability or neurodivergence as part of identity.
Person-first (e.g. person with a disability) emphasises the individual before the condition.
Language choice should always follow individual preference.

Inclusion
Ensuring all people can participate fully, feel valued and have their identities respected.

Intersectionality

A framework recognising how overlapping aspects of identity (e.g. race, disability, gender) create unique experiences of privilege or discrimination.

LGBTQIA+
An umbrella term for diverse sexual orientations and gender identities:

- **Lesbian** – a woman attracted to women.
- **Gay** – a person attracted to people of the same gender (often men, but also broader).
- **Bisexual** – attracted to more than one gender.
- **Transgender (Trans)** – gender identity differs from sex assigned at birth.
- **Queer/Questioning** – queer is a reclaimed inclusive term; questioning refers to exploring sexual or gender identity.
- **Intersex** – born with variations in sex characteristics that do not fit typical definitions of male or female.
- **Asexual** – experiences little or no sexual attraction (may still experience romantic attraction).
- **+ (Plus)** – recognises other identities, e.g., pansexual, non-binary, gender-fluid.

Lived experience
First-hand knowledge and insight gained from living with a condition, identity or system.

Microaggressions
Subtle, often unintentional, behaviours or comments that communicate bias or exclusion toward marginalised groups.

Multi-disciplinary team (MDT)
A group of professionals from different disciplines (e.g. occupational therapy, nursing, psychology, social work, medicine, speech and language therapy) working collaboratively to support people.

Neurodivergent/Neurodiversity
Describes people whose cognitive or sensory processing differs from typical expectations, including autism, ADHD, dyslexia, dyspraxia (developmental coordination disorder) and others.

Occupational alienation
A sense of meaninglessness or lack of purpose in everyday occupations due to external restrictions or systemic oppression.

Occupational deprivation
Prolonged exclusion from meaningful occupations caused by external factors such as poverty, discrimination or incarceration.

Occupational justice
The right of all people to participate in meaningful occupations that support health, identity and belonging.

People
Used in this guide instead of ‘service user’ or ‘patient’, to centre dignity, identity and humanity across all settings.

Power dynamics
The ways in which authority, privilege and social position shape relationships, opportunities and participation.

Privilege
Unearned advantages based on identity (e.g. whiteness, non-disability).

Profound and multiple learning disabilities (PMLD)/Complex disabilities
The term PMLD is widely used in NHS and healthcare documentation to describe people with profound intellectual impairments alongside physical, sensory or health needs. Many families and some disabled people prefer complex disabilities, which is seen as less medicalised and more

reflective of the whole person. Occupational therapists should be sensitive to individual and family preferences.

Psychological safety
An environment where people feel safe to ask questions, share ideas or admit mistakes without fear of ridicule or punishment.

Racism
A system of discrimination and power that privileges white people and disadvantages racially minoritised communities, operating at individual, institutional and systemic levels.

Reasonable adjustments
Legal and ethical changes to environments, processes or practices to remove barriers for disabled people under the Equality Act 2010.

Sexism
Discrimination or bias based on sex or gender, often rooted in stereotypes and unequal power.

Social model of disability
A framework that identifies disability as the result of barriers in society, not individual impairments.

Systemic oppression
Structural disadvantage built into institutions and systems that consistently harm certain groups.

Trauma-informed practice
Approaches that recognise the prevalence and impact of trauma and aim to provide safe, supportive and non-retraumatising care.

Transphobia
Prejudice, discrimination, or hostility towards people whose gender identity differs from the sex they were assigned at birth.

Royal College of Occupational Therapists

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