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A systematic review protocol on workplace equality and inclusion practices in the healthcare Sector.

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TITLE PAGE

Title A systematic review protocol on workplace equality and inclusion practices in the healthcare Sector.

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Keywords **"**Workplace equality and inclusion in healthcare", "migration of doctors and nurses", "multiculturalism within healthcare".

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ABSTRACT

Introduction:

While equality and inclusion practices in healthcare have been advanced from a service user perspective, little is known about the application of workplace equality and inclusion practices in healthcare. Thus, as healthcare becomes more internationalized with the migration of healthcare professionals it is imperative that healthcare organisations have robust and meaningful workplace equality and inclusion practices. As a result, health care organizations who welcome and value all their employees are more creative and productive, which can lead to better quality of care. Additionally, staff retention is maximized, and workforce integration will succeed. In view of this, this study aims to identify and synthesize current best evidence relating to workplace equality and inclusion practices in the healthcare sector.

Methods and Analysis:

Utilizing the Population, Intervention, Comparison and outcome (PICO) framework, a search of the following databases will be made - MEDLINE, CINAHL, EMBASE, SCOPUS, PsycInfo, ESBCO platforms and Google Scholar - using Boolean terms to identify peer-reviewed literatures concerning workplace equality and inclusion in healthcare from January 2010-2022. Should data be available, this research is focused on assessing what is workplace equality and inclusion; why it is important to promote workplace equality and inclusion in healthcare; how can workplace equality and inclusion practices be measured in healthcare; and how can workplace equality and inclusion be advanced in health systems.

Ethics and Dissemination:

Ethical approval is not required. Both a protocol and a systematic review paper are to be published concerning workplace equality and inclusion practices in the healthcare sector.

STRENGHTS AND LIMITATIONS OF THIS STUDY

- This study will inform a vast array of stakeholders within healthcare of the current state of play of workplace equality and inclusion in healthcare. As a result, this knowledge will contribute to future research in healthcare leadership development practices, healthcare cultural development practices and professional development practices in healthcare.
- This study will make a significant contribution to the existing body of knowledge and literature because it is one of the few studies that examines workplace equality and inclusion in healthcare.
- Databases using the English language only will be reviewed and assessed. As a result, this may introduce language bias.

Introduction

Across the globe, countries and societies are becoming increasingly multicultural, a phenomenon that is having a significant impact on workplace practices. "The increase in migration of nurses has an effect on healthcare systems" [1, p.2220]. As a result, working with employees from a variety of backgrounds, mangers should understand differing cultural perspectives and styles of thinking [2] as employees who are treated fairly and have equal opportunity are better able to contribute socially and economically to the community, and to enhance growth and prosperity within the organization [3]. In Europe, the principle of equality is deeply rooted in the European Union (EU). In more recent times, EU laws have been strengthened to guarantee equal opportunities in employment by banning discrimination in employment on the grounds of religious beliefs, age, sexual-orientation, and disability [4]. These developments aim to encourage member states within the EU framework to advance robust equality and inclusion practices in their societies.

The purpose of this paper is to present a protocol for a systematic review focused on workplace equality and inclusion practices in healthcare. The healthcare sector is considered to have one of the most ethnically diverse, highly skilled professional workforces driving the need for effective equality and inclusion practices [5]. Additionally, constructive equality and inclusion practices in the workplace is an important aspect of good people management. While the equality legislative framework, covering race, religion, gender, sexual orientation among others sets a minimum standard, robust equality and inclusion practices add value to the organization, contribute to employee well-being and engagement [6]. These practices include, good communication based on open dialogue and active listening; learning and development programs; continuous professional development (CPD) for all employees but, in particular for leaders and managers as their behavior advance and strengthen equality and inclusion in the healthcare arena. Moreover, considering the lacuna in the literature regarding equality of access to continuous professional development (CDP) programs across the different areas and levels of healthcare, it is imperative that key personnel in healthcare systems engage with equality and inclusion practices to ensure a level playing field is provided in professional and training development opportunities.

Health systems need health professionals to deliver health services, however there is a significant shortage of labor supply in this domain. In their study, the [7] notes "there is a chronic worldwide need for some 2.4 million more physicians, nurses and midwives, and for almost two million more pharmacists and other paramedical workers" (p.1). As a result, wealthy economies are depending on international migrants to fill healthcare roles, including nursing and medical positions. For instance, "4,684 newly-registered nurses and midwives in Ireland in 2017, almost 33 per cent were trained outside the EU and 37 per cent in other EU states" [8, para.2]. At the same time, while the Irish health care system is dependent on foreign health professionals, Irish nurses and doctors are leaving the health care system. According to

[9] 3,798 doctors migrated from Ireland to 5 key destinations (UK, Canada, NZ, Australia & the USA) between 2008-2014, and the Nursing and Midwifery Board of Ireland (NMBI) has seen a dramatic increase in requests for certificates of professional status, a document that is required by nurses to practice abroad. This suggests the Irish healthcare system is not meeting the needs of its health professionals. [10] comment that health force migration into and out of Ireland is possibly owing to monetary reasons, unclear career pathways and unsuitable working conditions. As regards the latter element, health care organizations need to consider their workplace equality and inclusion practices to ensure best practice is being modelled regarding its people management so that a sustainable workforce can be built and maintained to deliver premium health services.

According to [11] global migration can create many challenges in the provision of healthcare as native and foreign health-professionals need to be culturally sensitive of each other. This implies differences should be respected and appreciated. Moreover, "those who can identify shared goals that lie underneath the cultural differences are likely to have the greatest success and value" [3, p.67]. Nonetheless, "overseas nurses do face many different forms of discrimination from their managers, patients, and healthcare colleagues at some point during their professional life" [12, p.436]. As a result, this can impact on staff morale, productivity and organizational performance.

Having a globalized workforce in the health care arena in the western world is likely to continue going forward, thus, to improve workforce integration, [13] informs us that both national and international health care personnel need to recognize that two-way understanding and adaptation is necessary to build inclusivity. Work environments that show a willingness to understand employee differences in terms of thinking, working styles, forms of communication (both verbal and non-verbal) are high in psychological safety and engender high engagement amongst personnel [14]. Moreover, "institutional theory proposes that an organization is

influenced by its institutional environment which consists of formal and informal institutions" [15, p.57]. The former referring to "binding rules, such as laws" and the latter relating to "culture and conventions" [15, p.57]. In Ireland, the Employment Equality directive prohibits discrimination on several grounds including gender, marital status, age, disability, sexual orientation, race, religion [16]. As regards culture and the advancement of equality and inclusion principles, healthcare professionals must be aware of their "own cultural beliefs, values, attitudes before learning about other cultures. This need for awareness is predicated on the fact that cultural beliefs, values, attitudes and practices may vary considerably, and practitioners ought to be respectful of these differences. Being sensitive and adaptive to individual cultural differences relies on the professional's self-awareness and reflection and can lead to greater interpersonal cultural awareness" [11, p.385], minimization of unconscious bias, and effortless respect for people regardless of physical, mental, social, religious, political, educational, and professional differences. Thus, health practitioners need to reflect on 5 factors that may lead to "greater awareness of cultural competence: (1) valuing diversity (2) developing the capacity for cultural self-assessment (3) being conscious of interculture interaction (4) establishing institutionalized cultural knowledge and (5) developing adaptations of service delivery that reflect an understanding of cultural diversity" [2, p.532]. If these elements are implemented in interactions between health care professionals, inter-professional collaboration and teamwork will succeed in delivering care that is culturally sensitive [17].

One of the most researched and documented manifestations regarding equality and inclusion practices in healthcare organizations is related to gender. Appropriate equality and inclusion practices are historically driven by the fundamental need for gender equality. Traditionally, the medical profession was dominated by men, however since the 1970s the number of women doctors entering this profession has increased dramatically in the developed world. Despite these advancements, the quest for gender equality remains elusive as women remain

underrepresented in certain specialties in medicine and in top leadership positions in healthcare. Possible reasons for the continuation of gender inequality for these women might include (1) the glass ceiling (2) little or no mentoring (3) the culture (4) the responsibilities of domestic, clinical and leadership roles which can lead to higher burnout rate [18-19]. Thus, to recruit, retain and promote female doctors' health care organizations must develop meaningful inclusive strategies that support and value these people. Furthermore, [20] suggest that to advance equality and inclusion it's about challenging the structures that entrench inequality, but also about challenging our own behavior and attitudes, and those we experience every day. That said, [15] surmise that improving gender equality can be arduous as changing organizational culture can be demanding. While the Treaty of Rome was instrumental in establishing the principle of equal treatment in relation to access of employment, working conditions and training, the implementation of equality and inclusion varies in different contexts owing to different interpretations of these principles, perhaps explaining why there continues to be a substantial lack of female representation in positions of executive management and decision-making [14]. Interestingly, the WHO note that women make up 70 percent of the health workforce but only 25% hold senior roles. At the same time, the lack of implementation of equality and inclusion principles in the health care environment perhaps shows why "female nurses outnumber men by a ratio of 10 to 1 in the western world" [21, p.195]. Furthermore, this author observes that male nurses fail to explain the real reasons why they become nurses as caring for people may not be seen as masculine. This suggests if health professionals cannot be true to themselves in health care organizations, it is likely inequality and non-inclusivity will co-exist, which is extremely costly in terms of interprofessional collaborations, patient outcomes, and staff well-being.

Inclusive and strategic leaders try and get the best of their followers so that the organization can reach its goals and objectives. This can be challenging at times considering the uncertainty

in global markets. That said, new public management (NPM) practices which promote collaboration and engagement, multidisciplinary teams, and a bottom-up decision-making approach can lead to more effective outcomes for service users [22]. In view of this, when examining workplace practices concerning equality and inclusion in healthcare much less attention is given to these issues amongst healthcare staff in contrast to service users, where inequalities in health-care delivery is well researched [22]. Thus, this paucity in the research on equality and inclusion workplace practices supporting workforce integration in the delivery of health services must be addressed. Organizational leaders in healthcare must deliver a more culturally sensitive, inclusive environment to retain medical personnel, enhance job satisfaction and increase organizational commitment. Practitioners in the healthcare industry must be encouraged to examine their own cultural biases and behaviours as a foundation for progressing toward becoming culturally competent both in individual practice and at an organizational level [11].

It is imperative that all health care systems worldwide have workforce integration, which is conditioned by egalitarianism and intercultural understanding [13] that incorporates principles of pluralism, equality and inclusion so that future healthcare needs can be catered for by native and international health professionals working side by side. The growing responsibility of healthcare organizations to design systems that target equality and inclusion practices for their employees requires a sound evidenced based approach in the development process. *Thus, the research question of this study is: what is the current best evidence relating to workplace equality and inclusion practices in healthcare*?

Methods and analysis

This study uses the PRISMA-Reporting guidelines [23].

Study Design

To summarize workplace equality and inclusion practices in healthcare we use the Population, Intervention, Comparison and outcome (PICO) framework to facilitate the literature search.

- In the [population] segment we are concerned with identifying equality and inclusion practices amongst the health care workforces. Specifically, we focus on clinicians, nursing, and allied health professionals.

- In the [Intervention] aspect we assess what promotes equality and inclusion amongst practitioners compared [Comparison] to exclusion and inequality.

- The outcome seeks to focus on enhanced inter-professional collaborations, teamwork and engagement in the organization, equality of access across the different areas and levels of healthcare for CPD and career advancement.

Inclusion/exclusion criteria

We will include studies that satisfy all of the following criteria:

1 Studies that describe workplace equality and inclusion practices in healthcare.

2 Studies that focus on equality and inclusion workplace practices that relate to workforce integration, inter-professional collaborations, teamwork, engaged workforce.

3 Studies which discuss the cultural context of healthcare with respect to the impact of the culture on equality practices.

4 Given that the momentum for equality and inclusion has occurred since the late 2000, studies from 2010 onwards are included in this systematic review.

We will exclude papers where any of the following apply:

1 Studies that describe equality and inclusion from a service user perspective as the focus of this work is on workplace equality and inclusion practices.

2 Reviews, Letters, and personal correspondence.

3 Articles in a language other than English.

Search methods

Studies will be identified by searching the medical literatures using Medline on Pubmed, Ovid and EBSCO platforms, Cinahl Complete, Embase, PsycINFO and Scopus to identify primary articles reporting on workplace equality and inclusion practices in healthcare. We will utilize different combinations of the Boolean phrases outlined in Table 1 to identify current best evidence relating to workplace equality and inclusion practices in healthcare.

Table 1 Boolean phrases

Equality AND Inclusion; Equality AND Inclusion AND Healthcare; Staff Equality AND Inclusion AND Leadership/ Professional Development/ Training and Development/ Staff Development/ Mentoring; Healthcare Employees AND Equality AND Culture.

Additionally, citation lists of previous protocols (relating to workplace equality and inclusion in healthcare) and the reference list of papers identified in the above search will be reviewed to ensure all relevant medical literature is captured in evaluating the evidence regarding workplace equality and inclusion practices in healthcare.

Moreover, it is important to note too we will utilize Google Scholar as a control to ensure all relevant literature is detected in relation to workplace equality and inclusion practices in healthcare.

Patient and Public Involvement

No patient or public are involved in this study.

Study selection and Quality appraisal

Firstly, the titles, abstracts, and key words of all the selected medical literature will be read by two members of the team to ensure these works are relevant to workplace equality and inclusion practices in healthcare. The inclusion principles outlined above will guide the reader's decision-making process in ensuring the literature is within the scope of this research project. Papers that do not centre on workplace equality and inclusion practices in healthcare are removed from the process. To ensure a fair, balanced and transparent approach is employed in the study selection process, a third reviewer is available to consult should they be differences of opinion between the primary readers as regards what literature should be included or excluded in the process.

Following this, the full text of the relevant literature will be read in detail to ensure it is within the scope of this study. It is important to note the third reviewer is always available to discuss should there be divergences of opinion between readers one and two as it is crucial that all eligible relevant works are incorporated in evaluating workplace equality and inclusion practices in healthcare.

Finally, all stages of the study selection process (identification; screening; eligibility and inclusion) will be outlined in a flow diagram (i.e., preferred reporting items for systematic reviews and meta-analyses – PRISMA).

Analysis

Where available, data pertaining to the following themes will be extracted from the eligible papers:

- Motivation for assessing workplace equality and inclusion practices in healthcare
- Definition of equality and inclusion principles
- A review of how equality and inclusion is measured.
- Discussion on how we can promote and advance equality and inclusion practices.

Ethics and dissemination

Ethical approval is not required. In terms of dissemination, the focus of summer 2022 is to publish both a protocol and a systematic review of workplace equality and inclusion practices in the healthcare sector.

Author contributions

SNL, NR and RL conceptualized the study together. All authors engaged in research to support the writing of the paper. SNL compiled the research in the form of the protocol paper. NR and RL proof-read and edited the paper.

Funding Statement

This work was supported by the Health Sciences Academy at the University of Limerick. The total amount of funding given to the project is €3,000.

Competing Interests Statement

None

Data Sharing Statement

No primary data has been collected for the purposes of this paper.

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Reporting checklist for protocol of a systematic review and meta analysis.

Based on the PRISMA-P guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the PRISMA-Preporting guidelines, and cite them as:

Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart LA. Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 2015 statement. Syst Rev. 2015;4(1):1.

		Reporting Item	Page Number
Title			
Identification	#1a	Identify the report as a protocol of a systematic review	1
Update	#1b	If the protocol is for an update of a previous systematic review, identify as such	N/A

Registration			
	#2	If registered, provide the name of the registry (such as PROSPERO) and registration number	N/A
Authors			
Contact	#3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1
Contribution	#3b	Describe contributions of protocol authors and identify the guarantor of the review	12
Amendments			
	#4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	N/A
Support			
Sources	#5a	Indicate sources of financial or other support for the review	12
Sponsor	#5b	Provide name for the review funder and / or sponsor	1/12
Role of sponsor or funder	#5c	Describe roles of funder(s), sponsor(s), and / or institution(s), if any, in developing the protocol	N/A
Introduction			

Rationale	#6	Describe the rationale for the review in the context of what is already known	2/4/8
Objectives	#7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	9
Methods			
Eligibility criteria	#8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	9/10
Information sources	#9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	10/11
Search strategy	#10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	N/A
Study records - data management	#11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	N/A
Study records - selection process	#11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	11

Study records - data collection process	#11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	11
Data items	#12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	12
Outcomes and prioritization	#13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	N/A
Risk of bias in individual studies	#14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	N/A
Data synthesis	#15a	Describe criteria under which study data will be quantitatively synthesised	N/A
Data synthesis	#15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I2, Kendall's τ)	N/A
Data synthesis	#15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	N/A

Data synthesis	#15d	If quantitative synthesis is not appropriate, describe the type of summary planned	N/A
Meta-bias(es)	#16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	N/A
Confidence in cumulative evidence	#17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	N/A

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TITLE PAGE

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Keywords Workplace equality and inclusion in healthcare, migration of doctors and nurses, multiculturalism within healthcare.

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No. of References: 28

ABSTRACT

Introduction:

While equality and inclusion practices in healthcare have been advanced from a service user perspective, little is known about the application of workplace equality and inclusion practices in healthcare. Nonetheless, in the developed world, the composition of the healthcare workforce is changing, with nationals and non-nationals working 'side-by-side' suggesting that healthcare organisations must have robust and meaningful workplace equality and inclusion practices. Health care organizations who welcome and value all their employees are more creative and productive, which can lead to better quality of care. Additionally, staff retention is maximized, and workforce integration will succeed. In view of this, this study aims to identify and synthesize current best evidence relating to workplace equality and inclusion practices in the healthcare sector.

Methods and Analysis:

Utilizing the Population, Intervention, Comparison and outcome (PICO) framework, a search of the following databases will be made - MEDLINE, CINAHL, EMBASE, SCOPUS, PsycInfo, Business Source Complete and Google Scholar - using Boolean terms to identify peer-reviewed literatures concerning workplace equality and inclusion in healthcare from January 2010-2022. A thematic approach will be employed to appraise and analyse the extracted data with the view to assessing what is workplace equality and inclusion; why it is important to promote workplace equality and inclusion in healthcare; how can workplace equality and inclusion practices be measured in healthcare; and how can workplace equality and inclusion be advanced in health systems.

Ethics and Dissemination:

Ethical approval is not required. Both a protocol and a systematic review paper are to be published concerning workplace equality and inclusion practices in the healthcare sector.

STRENGHTS AND LIMITATIONS OF THIS STUDY

- Identifying and synthesizing workplace equality and inclusion practices relating to staff development in healthcare.
- The search strategy incorporates up-to-date research based on a timeframe that ranges from 2010-2022.
- Research in relation to all healthcare employees will be included in the evaluation of workplace equality and inclusion practice literature.
- Only peer-reviewed articles published in English will be included.
- The first of its type, this review will make academic findings into this area more accessible to academic and organisational decision makers.

Introduction

Across the globe, countries and societies are becoming increasingly diverse, a phenomenon that is having a significant impact on workplace practices. For instance, in 2020 the US health care workforce comprised of more than 50 percent white, approximately 20 percent Asian, 7 percent black, and less than 1 percent Hispanic and native American workers [1] relative to the turn of the century whereby less non-natives participated in the health labour force. Moreover, the commentators [2, p.2220] note "the increase in migration of nurses has an effect on healthcare systems". As a result, working with employees from a variety of backgrounds, mangers should understand differing cultural perspectives and styles of thinking [3] as employees who are treated fairly and have equal opportunity are better able to contribute

socially and economically to the community, and to enhance growth and prosperity within the organization [4]. In particular, embedding robust workforce equality and inclusion practices in healthcare leads to mutual desired benefits for health systems. Health professionals that are treated fairly and are included in the decision-making process are engaged and motivated which impacts on the quality of service. At the same time, these strategies support the workforce to treat the myriad of needs and populations that the health systems serve [1]. In Europe, the principle of equality is deeply rooted in the European Union (EU). In more recent times, EU laws have been strengthened to guarantee equal opportunities in employment by banning discrimination in employment on the grounds of religious beliefs, age, sexual-orientation, and disability [5]. These developments aim to encourage member states within the EU framework to advance robust equality and inclusion practices in their societies.

The purpose of this paper is to present a protocol for a systematic review which is concerned with classifying and synthesizing workplace equality and inclusion practices in healthcare with respect to staff development. This is motivated by a healthcare system that is considered to have one of the most ethnically diverse, highly skilled professional workforces driving the need for effective equality and inclusion practices [6]. Additionally, constructive equality and inclusion practices in the workplace is an important aspect of good people management. While the equality legislative framework, covering race, religion, gender, sexual orientation among others sets a minimum standard, robust equality and inclusion practices add value to the organization, contribute to employee well-being and engagement and impact on service delivery [7]. These practices include, good communication based on open dialogue and active listening to all employees; learning and development programs; continuous professional development (CPD) for all subordinates but, in particular for leaders and managers as their behavior advance and strengthen equality and inclusion in the healthcare arena. Delivering patient safety care is dependent on the coordination of actions between doctors, nurses and

other allied health professionals within a team. The commentators, [8] note that teamwork requires a number of core competencies, including leadership, mutual support and communication. These core competencies are supported by trust and a shared vision of patient care amongst healthcare professionals. Training and development can improve the team performance by upwards of 20 percent [9], thus it is imperative that all healthcare employees across the different areas and levels of healthcare, have an opportunity to engage with CPD programs.

Developed economies can provide resources – such as money, knowledge, education and economic opportunities which can increase an individual's aspirations to migrate rather than remain in the local economy [10]. While western Europe has become a global destination of migrants, it is important to note "global migration has not accelerated" (10, p.889). Instead, the demand for skilled labour in specialized labour markets has become more accelerated. In terms of healthcare, health systems need health professionals to deliver health services, however there is a significant shortage of labor supply in this domain. In their study, the [11] notes "there is a chronic worldwide need for some 2.4 million more physicians, nurses and midwives, and for almost two million more pharmacists and other paramedical workers" (p.1). This implies that middle-high income countries might need to source labour supply from outside of its native shores to delivery medical services. For example, in the United Kingdom (UK) the proportion of non-British nationals in the healthcare workforce has remained broadly stable since 2012, but at the same time the numbers have increased from 155,000 to 227,000, with EU nationals accounting for most of the increase. Similarly, in the Irish health care system it is reliant on non-Irish personnel to deliver health services. For instance, of the "4,684 newly-registered nurses and midwives in Ireland in 2017, almost 33 per cent were trained outside the EU and 37 per cent in other EU states" [12, p.1, para.2]. This shows that native and international staff are working side by side to deliver quality medical services. To advance and promote a harmonious

and collaborative working environment, it is imperative healthcare organizations put in place meaningful workplace equality and inclusion practices. Furthermore, it is also important to note that while the recruitment of international health personnel provides the destination country with healthcare staff, the WHO Code of practice on international recruitment of health personnel advocates that recruiting countries have a responsibility to strengthen the health workforce of less developed countries as building a sustainable workforce leads to a reduction inequality.

Global migration can create many challenges in the provision of healthcare as native and foreign health-professionals need to be culturally sensitive of each other [13]. This implies differences should be respected and appreciated. Moreover, "those who can identify shared goals that lie underneath the cultural differences are likely to have the greatest success and value" [4, p.67]. Nonetheless, "overseas nurses do face many different forms of discrimination from their managers, patients, and healthcare colleagues at some point during their professional life" [14, p.436]. As a result, this can impact on staff morale, productivity and organizational performance.

Having a globalized workforce in the health care arena in the western world is likely to continue going forward, thus, to improve workforce integration, [15] informs us that both national and international health care personnel need to recognize that two-way understanding and adaptation is necessary to build inclusivity. The authors [16] suggest that collaboration and teamwork lead to enhanced staff well-being and better patient care. Effective inter-professional collaboration and teamwork requires coordination across the professions, boundaries and a sense of openness from each of the multiple professions [17]. As a result, inclusive and well-functioning teams can improve health outcomes.

Moreover, work environments that show a willingness to understand employee differences in terms of thinking, working styles, forms of communication (both verbal and non-verbal) are high in psychological safety and engender high engagement amongst personnel [18]. Furthermore, "institutional theory proposes that an organization is influenced by its institutional environment which consists of formal and informal institutions" [19, p.57]. The former referring to "binding rules, such as laws" and the latter relating to "culture and conventions" [19, p.57]. In Ireland, the Employment Equality directive prohibits discrimination on several grounds including gender, marital status, age, disability, sexual orientation, race, religion [20]. As regards culture and the advancement of equality and inclusion principles, healthcare professionals must be aware of their "own cultural beliefs, values, attitudes before learning about other cultures. This need for awareness is predicated on the fact that cultural beliefs, values, attitudes and practices may vary considerably, and practitioners ought to be respectful of these differences. Being sensitive and adaptive to individual cultural differences relies on the professional's self-awareness and reflection and can lead to greater interpersonal cultural awareness" [13, p.385], minimization of unconscious bias, and effortless respect for people regardless of physical, mental, social, religious, political, educational, and professional differences. Thus, health practitioners need to reflect on 5 factors that may lead to "greater awareness of cultural competence: (1) valuing diversity (2) developing the capacity for cultural self-assessment (3) being conscious of interculture interaction (4) establishing institutionalized cultural knowledge and (5) developing adaptations of service delivery that reflect an understanding of cultural diversity" [3, p.532]. If these elements are implemented in interactions between health care professionals, inter-professional collaboration and teamwork will succeed in delivering care that is culturally sensitive [21].

One of the most researched and documented manifestations regarding equality and inclusion practices in healthcare organizations is related to gender. Appropriate equality and inclusion

practices are historically driven by the fundamental need for gender equality. Traditionally, the medical profession was dominated by men, however since the 1970s the number of women doctors entering this profession has increased dramatically in the developed world. Despite these advancements, the quest for gender equality remains elusive as women remain underrepresented in certain specialties in medicine and in top leadership positions in healthcare. Possible reasons for the continuation of gender inequality for these women might include (1) the glass ceiling (2) little or no mentoring (3) the culture (4) the responsibilities of domestic, clinical and leadership roles which can lead to higher burnout rate [22-23]. Thus, to recruit, retain and promote female doctors' health care organizations must develop meaningful inclusive strategies that support and value these people. Furthermore, [24] suggest that to advance equality and inclusion it's about challenging the structures that entrench inequality, but also about challenging our own behavior and attitudes, and those we experience every day. That said, [19] surmise that improving gender equality can be arduous as changing organizational culture can be demanding. While the Treaty of Rome was instrumental in establishing the principle of equal treatment in relation to access of employment, working conditions and training, the implementation of equality and inclusion varies in different contexts owing to different interpretations of these principles, perhaps explaining why there continues to be a substantial lack of female representation in positions of executive management and decision-making [18].

Women constitute almost 78 percent of the health workforce; however, the majority of female posts relate to the operations side of healthcare [25]. While women have a central role in the delivery of healthcare, their representation in positions of greater responsibility and decision-making is very limited [26], suggesting that to advance gender parity in leadership positions in healthcare it is imperative that workplace equality and inclusion practices are infused into the workplace culture.

Inclusive and strategic leaders try and get the best of their followers so that the organization can reach its goals and objectives. Transformational leadership calls for collaboration and engagement amongst healthcare colleagues and a two-way approach in terms of communication. These behaviours can lead to greater sense of well-being amongst team members, which in turn leads to more effective outcomes for service users. Interestingly, when examining workplace practices concerning equality and inclusion in healthcare much less attention is given to these issues amongst healthcare staff in contrast to service users, where inequalities in health-care delivery is well researched [27]. Thus, this paucity in the research on equality and inclusion workplace practices supporting workforce integration in the delivery of health services must be addressed. Specifically, organizational leaders in healthcare must deliver a more culturally sensitive, inclusive environment to retain medical personnel, enhance job satisfaction and increase organizational commitment. Practitioners in the healthcare industry must be encouraged to examine their own cultural biases and behaviours as a foundation for progressing toward becoming culturally competent both in individual practice and at an organizational level [13].

It is imperative that all health care systems worldwide have workforce integration, which is conditioned by egalitarianism and intercultural understanding [15] that incorporates principles of pluralism, equality and inclusion so that future healthcare needs can be catered for by native and international health professionals working side by side. The growing responsibility of healthcare organizations to design systems that target equality and inclusion practices for their employees requires a sound evidenced based approach in the development process. *Thus, the research question of this study is: what is the current best evidence relating to workplace equality and inclusion practices in healthcare*?

Methods and analysis

This study uses the PRISMA-Reporting guidelines [28]

Study Design

To summarize workplace equality and inclusion practices in healthcare we use the Population, Intervention, Comparison and outcome (PICO) framework to facilitate the literature search.

- In the [population] segment we are concerned with identifying equality and inclusion practices amongst the healthcare employees.
- In the [Intervention] aspect we assess what promotes equality and inclusion amongst practitioners compared [Comparison] to exclusion and inequality.
- The outcome seeks to focus on enhanced inter-professional collaborations, teamwork and engagement in the organization, equality of access across the different areas and levels of healthcare for CPD and career advancement.

Inclusion/exclusion criteria

We will include studies that satisfy all of the following criteria:

1 Studies that describe workplace equality and inclusion practices in healthcare.

2 Studies that focus on equality and inclusion workplace practices that relate to workforce integration, inter-professional collaborations, teamwork, engaged workforce.

3 Studies which discuss the cultural context of healthcare with respect to the impact of the culture on equality practices.

4 Given that the momentum for equality and inclusion has occurred since the late 2000, studies from 2010 onwards are included in this systematic review.

We will exclude papers where any of the following apply:

1 Studies that describe equality and inclusion from a service user perspective as the focus of this work is on workplace equality and inclusion practices.

2 Reviews, Letters, and personal correspondence.

3 Articles in a language other than English.

Search methods

Studies will be identified by searching the medical literatures using Medline (Pubmed & Ovid), Business Source Complete, Cinahl Complete, Embase, PsycINFO and Scopus to identify primary articles reporting on workplace equality and inclusion practices in healthcare. We will utilize different combinations of the Boolean phrases outlined in Table 1 to identify current best evidence relating to workplace equality and inclusion practices in healthcare.

Table 1 Boolean phrases

Equality AND Inclusion; Equality AND Inclusion AND Healthcare; Staff Equality AND Inclusion AND Leadership/ Professional Development/ Training and Development/ Staff Development/ Mentoring; Healthcare Employees AND Equality AND Culture.

Additionally, citation lists of previous protocols (relating to workplace equality and inclusion in healthcare) and the reference list of papers identified in the above search will be reviewed to ensure all relevant medical literature is captured in evaluating the evidence regarding workplace equality and inclusion practices in healthcare.

Moreover, it is important to note too we will utilize Google Scholar as a control to ensure all relevant literature is detected in relation to workplace equality and inclusion practices in healthcare.

Study Timeframe

Anticipated Start Time: January 2023

Anticipated End Date April 2023

Patient and Public Involvement

No patient or public are involved in this study.

Study selection and Quality appraisal

Firstly, the titles, abstracts, and key words of all the selected medical literature will be read by two members of the team to ensure these works are relevant to workplace equality and inclusion practices in healthcare. The inclusion principles outlined above will guide the reader's decision-making process in ensuring the literature is within the scope of this research project. Papers that do not centre on workplace equality and inclusion practices in healthcare are removed from the process. To ensure a fair, balanced and transparent approach is employed in the study selection process, a third reviewer is available to consult should they be differences of opinion between the primary readers as regards what literature should be included or excluded in the process.

Following this, the full text of the relevant literature will be read in detail to ensure it is within the scope of this study. It is important to note the third reviewer is always available to discuss should there be divergences of opinion between readers one and two as it is crucial that all eligible relevant works are incorporated in evaluating workplace equality and inclusion practices in healthcare.

Finally, all stages of the study selection process (identification; screening; eligibility and inclusion) will be outlined in a flow diagram (i.e., preferred reporting items for systematic reviews and meta-analyses – PRISMA).

Analysis

Thematic analysis will be employed to evaluate and appraise the data in relation to the following themes:

- Motivation for assessing workplace equality and inclusion practices in healthcare
- Definition of equality and inclusion principles
- A review of how equality and inclusion is measured.
- Discussion on how we can promote and advance equality and inclusion practices.

Ethics and dissemination

Ethical approval is not required. In terms of dissemination, the focus of summer 2022 is to publish both a protocol and a systematic review of workplace equality and inclusion practices in the healthcare sector.

Author contributions

SNL, NR and RL conceptualized the study together. All authors engaged in research to support the writing of the paper. SNL compiled the research in the form of the protocol paper. NR and RL proof-read and edited the paper.

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Competing Interests Statement

None

Data Sharing Statement

No primary data has been collected for the purposes of this paper.

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Search Strategy for all Databases

1 Significant consultations with

(A) Librarian, Learning and Engagement Kemmy Business School, Mr. Peter Reilly and

(B) Librarian, Health Research Methods, Ms. Liz Dors

regarding relevant Databases and appropriate Boolean Terms.

2 Databases that needed to be screened for this study

A Cinahl Complete
B Embase
C PsycInfo
D Scopus
E Medline (Pubmed & Ovid)
F Business Source Complete
G Google Scholar

3 After consultation with the above librarians, the following Boolean Terms were utilized in the above search engines:

A Equality and Inclusion
B Equality and Inclusion and healthcare
C Staff Equality and Inclusion and leadership
D Staff Equality and Inclusion and Professional development
E Staff Equality and Inclusion and training and development
F Staff Equality and Inclusion and staff development
G Staff Equality and Inclusion and mentoring
H Healthcare Employees and Equality and Culture

Note

(1) In the above search, the word "***and***" is utilized to ensure all search engines cover all search terms simultaneously, for example equality and inclusion. This is a vital step in the process as excluding the word "and" means articles relating to equality are included only.

4 Filters

The following filters were applied in the above search engines:

A Publication Date (2010-2022)

Note: *The researcher could customize the dates, meaning the end date is the most recent (3rd November 2022)*

B Article Type – peer reviewed articles

5 Additional Filters

Limited to English language

6 Saving Citations

Citations will be saved to Endnote

Note: *The researcher can eliminate duplication of files*

Reporting checklist for protocol of a systematic review and meta analysis.

Based on the PRISMA-P guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the PRISMA-Preporting guidelines, and cite them as:

Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart LA. Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 2015 statement. Syst Rev. 2015;4(1):1.

		Reporting Item	Page Number
Title			
Identification	#1a	Identify the report as a protocol of a systematic review	1
Update	#1b	If the protocol is for an update of a previous systematic review, identify as such	N/A

Registration			
	#2	If registered, provide the name of the registry (such as PROSPERO) and registration number	380179
Authors			
Contact	#3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1
Contribution	#3b	Describe contributions of protocol authors and identify the guarantor of the review	13
Amendments			
	#4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	N/A
Support			
Sources	#5a	Indicate sources of financial or other support for the review	12
Sponsor	#5b	Provide name for the review funder and / or sponsor	1/13
Role of sponsor or funder	#5c	Describe roles of funder(s), sponsor(s), and / or institution(s), if any, in developing the protocol	N/A
Introduction			

Rationale	#6	Describe the rationale for the review in the context of what is already known	2/4
Objectives	#7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	10
Methods			
Eligibility criteria	#8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	10-12
Information sources	#9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	11-12
Search strategy	#10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	See Search strategy supplment
Study records - data management	#11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	N/A
Study records - selection process	#11b	State the process that will be used for selecting studies (such as two independent reviewers) through each	12

		phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	
Study records - data collection process	#11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	13
Data items	#12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	
Outcomes and prioritization	#13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	N/A
Risk of bias in individual studies	#14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	12
Data synthesis	#15a	Describe criteria under which study data will be quantitatively synthesised	N/A
Data synthesis	#15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I2, Kendall's τ)	N/A

Data synthesis	#15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	N/A
Data synthesis	#15d	If quantitative synthesis is not appropriate, describe the type of summary planned	N/A
Meta-bias(es)	#16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	N/A
Confidence in cumulative evidence	#17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	N/A

 This checklist can be completed online using https://www.goodreports.org/, a tool made by the EQUATOR Network in collaboration with Penelope.ai

BMJ Open

A systematic review protocol on workplace equality and inclusion practices in the healthcare Sector.

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Keywords:	Human resource management < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, International health services < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Organisational development < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

TITLE PAGE

Title A systematic review protocol on workplace equality and inclusion practices in the healthcare sector.

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Keywords Workplace equality and inclusion in healthcare, migration of doctors and nurses, multiculturalism within healthcare.

Word Count in overall Document: 3307
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No. of References: 28

ABSTRACT

Introduction:

While equality and inclusion practices in healthcare have been advanced from a service user perspective, little is known about the application of workplace equality and inclusion practices in healthcare on upper-middle- and high-income countries. In the developed world, the composition of the healthcare workforce is changing, with nationals and non-nationals working 'side-by-side' suggesting that healthcare organisations must have robust and meaningful workplace equality and inclusion practices. Health care organizations who welcome and value all their employees are more creative and productive, which can lead to better quality of care. Additionally, staff retention is maximized, and workforce integration will succeed. In view of this, this study aims to identify and synthesize current best evidence relating to workplace equality and inclusion practices in the healthcare sector in middle- and high-income economies.

Methods and Analysis:

Utilizing the Population, Intervention, Comparison and outcome (PICO) framework, a search of the following databases will be made - MEDLINE, CINAHL, EMBASE, SCOPUS, PsycInfo, Business Source Complete and Google Scholar - using Boolean terms to identify peer-reviewed literatures concerning workplace equality and inclusion in healthcare from January 2010-2022 (see supplementary file 1). A thematic approach will be employed to appraise and analyse the extracted data with the view to assessing what is workplace equality and inclusion; why it is important to promote workplace equality and inclusion in healthcare; how can workplace equality and inclusion practices be measured in healthcare; and how can workplace equality and inclusion be advanced in health systems.

Ethics and Dissemination:

Ethical approval is not required. Both a protocol and a systematic review paper are to be published concerning workplace equality and inclusion practices in the healthcare sector.

STRENGHTS AND LIMITATIONS OF THIS STUDY

- Identifying and synthesizing workplace equality and inclusion practices relating to staff development in healthcare.
- The search strategy incorporates up-to-date research based on a timeframe that ranges from 2010-2022.
- Research in relation to all healthcare employees will be included in the evaluation of workplace equality and inclusion practice literature.
- Only peer-reviewed articles published in English will be included. We are cognisant that relying on English-language studies may not represent all of the evidence as it can create a language bias, however recent studies have shown minimal effect on the effect estimates and the overall conclusions of systematic reviews.
- The first of its type, this review will make academic findings into this area more accessible to academic and organisational decision makers.

Introduction

Across the globe, countries and societies are becoming increasingly diverse, a phenomenon that is having a significant impact on workplace practices. For instance, in 2020 the US health care workforce comprised of more than 50 percent white, approximately 20 percent Asian, 7 percent black, and less than 1 percent Hispanic and native American workers [1] relative to the turn of the century whereby less non-natives participated in the health labour force. Moreover, the commentators [2, p.2220] note “the increase in migration of nurses has an effect on

healthcare systems". As a result, working with employees from a variety of backgrounds, mangers should understand differing cultural perspectives and styles of thinking [3] as employees who are treated fairly and have equal opportunity are better able to contribute socially and economically to the community, and to enhance growth and prosperity within the organization [4]. In particular, embedding robust workforce equality and inclusion practices in healthcare leads to mutual desired benefits for health systems. Health professionals that are treated fairly and are included in the decision-making process are engaged and motivated which impacts on the quality of service. At the same time, these strategies support the workforce to treat the myriad of needs and populations that the health systems serve [1]. In Europe, the principle of equality is deeply rooted in the European Union (EU). In more recent times, EU laws have been strengthened to guarantee equal opportunities in employment by banning discrimination in employment on the grounds of religious beliefs, age, sexual-orientation, and disability [5]. These developments aim to encourage member states within the EU framework to advance robust equality and inclusion practices in their societies.

The purpose of this paper is to present a protocol for a systematic review which is concerned with classifying and synthesizing workplace equality and inclusion practices in healthcare with respect to staff development. This is motivated by a healthcare system that is considered to have one of the most ethnically diverse, highly skilled professional workforces driving the need for effective equality and inclusion practices [6]. Additionally, constructive equality and inclusion practices in the workplace is an important aspect of good people management. While the equality legislative framework, covering race, religion, gender, sexual orientation among others sets a minimum standard, robust equality and inclusion practices add value to the organization, contribute to employee well-being and engagement and impact on service delivery [7]. These practices include, good communication based on open dialogue and active listening to all employees; learning and development programs; continuous professional

development (CPD) for all subordinates but, in particular for leaders and managers as their behavior advance and strengthen equality and inclusion in the healthcare arena. Delivering patient safety care is dependent on the coordination of actions between doctors, nurses and other allied health professionals within a team. The commentators, [8] note that teamwork requires a number of core competencies, including leadership, mutual support and communication. These core competencies are supported by trust and a shared vision of patient care amongst healthcare professionals. Training and development can improve the team performance by upwards of 20 percent [9], thus it is imperative that all healthcare employees across the different areas and levels of healthcare, have an opportunity to engage with CPD programs.

Developed economies can provide resources – such as money, knowledge, education and economic opportunities which can increase an individual's aspirations to migrate rather than remain in the local economy [10]. While western Europe has become a global destination of migrants, it is important to note "global migration has not accelerated" (10, p.889). Instead, the demand for skilled labour in specialized labour markets has become more accelerated. In terms of healthcare, health systems need health professionals to deliver health services, however there is a significant shortage of labor supply in this domain. In their study, the [11] notes "there is a chronic worldwide need for some 2.4 million more physicians, nurses and midwives, and for almost two million more pharmacists and other paramedical workers" (p.1). This implies that middle-high income countries might need to source labour supply from outside of its native shores to delivery medical services. For example, in the United Kingdom (UK) the proportion of non-British nationals in the healthcare workforce has remained broadly stable since 2012, but at the same time the numbers have increased from 155,000 to 227,000, with EU nationals accounting for most of the increase. Similarly, in the Irish health care system it is reliant on non-Irish personnel to deliver health services. For instance, of the "4,684 newly-registered

nurses and midwives in Ireland in 2017, almost 33 per cent were trained outside the EU and 37 per cent in other EU states" [12, p.1, para.2]. This shows that native and international staff are working side by side to deliver quality medical services. To advance and promote a harmonious and collaborative working environment, it is imperative healthcare organizations put in place meaningful workplace equality and inclusion practices. Furthermore, it is also important to note that while the recruitment of international health personnel provides the destination country with healthcare staff, the WHO Code of practice on international recruitment of health personnel advocates that recruiting countries have a responsibility to strengthen the health workforce of less developed countries as building a sustainable workforce leads to a reduction inequality.

Global migration can create many challenges in the provision of healthcare as native and foreign health-professionals need to be culturally sensitive of each other [13]. This implies differences should be respected and appreciated. Moreover, "those who can identify shared goals that lie underneath the cultural differences are likely to have the greatest success and value" [4, p.67]. Nonetheless, "overseas nurses do face many different forms of discrimination from their managers, patients, and healthcare colleagues at some point during their professional life" [14, p.436]. As a result, this can impact on staff morale, productivity and organizational performance.

Having a globalized workforce in the health care arena in the western world is likely to continue going forward, thus, to improve workforce integration, [15] informs us that both national and international health care personnel need to recognize that two-way understanding and adaptation is necessary to build inclusivity. The authors [16] suggest that collaboration and teamwork lead to enhanced staff well-being and better patient care. Effective inter-professional collaboration and teamwork requires coordination across the professions, boundaries and a

sense of openness from each of the multiple professions [17]. As a result, inclusive and well-functioning teams can improve health outcomes.

Moreover, work environments that show a willingness to understand employee differences in terms of thinking, working styles, forms of communication (both verbal and non-verbal) are high in psychological safety and engender high engagement amongst personnel [18]. Furthermore, "institutional theory proposes that an organization is influenced by its institutional environment which consists of formal and informal institutions" [19, p.57]. The former referring to "binding rules, such as laws" and the latter relating to "culture and conventions" [19, p.57]. In Ireland, the Employment Equality directive prohibits discrimination on several grounds including gender, marital status, age, disability, sexual orientation, race, religion [20]. As regards culture and the advancement of equality and inclusion principles, healthcare professionals must be aware of their "own cultural beliefs, values, attitudes before learning about other cultures. This need for awareness is predicated on the fact that cultural beliefs, values, attitudes and practices may vary considerably, and practitioners ought to be respectful of these differences. Being sensitive and adaptive to individual cultural differences relies on the professional's self-awareness and reflection and can lead to greater interpersonal cultural awareness" [13, p.385], minimization of unconscious bias, and effortless respect for people regardless of physical, mental, social, religious, political, educational, and professional differences. Thus, health practitioners need to reflect on 5 factors that may lead to "greater awareness of cultural competence: (1) valuing diversity (2) developing the capacity for cultural self-assessment (3) being conscious of interculture interaction (4) establishing institutionalized cultural knowledge and (5) developing adaptations of service delivery that reflect an understanding of cultural diversity" [3, p.532]. If these elements are implemented in interactions between health care professionals, inter-professional collaboration and teamwork will succeed in delivering care that is culturally sensitive [21].

One of the most researched and documented manifestations regarding equality and inclusion practices in healthcare organizations is related to gender. Appropriate equality and inclusion practices are historically driven by the fundamental need for gender equality. Traditionally, the medical profession was dominated by men, however since the 1970s the number of women doctors entering this profession has increased dramatically in the developed world. Despite these advancements, the quest for gender equality remains elusive as women remain underrepresented in certain specialties in medicine and in top leadership positions in healthcare. Possible reasons for the continuation of gender inequality for these women might include (1) the glass ceiling (2) little or no mentoring (3) the culture (4) the responsibilities of domestic, clinical and leadership roles which can lead to higher burnout rate [22-23]. Thus, to recruit, retain and promote female doctors' health care organizations must develop meaningful inclusive strategies that support and value these people. Furthermore, [24] suggest that to advance equality and inclusion it's about challenging the structures that entrench inequality, but also about challenging our own behavior and attitudes, and those we experience every day. That said, [19] surmise that improving gender equality can be arduous as changing organizational culture can be demanding. While the Treaty of Rome was instrumental in establishing the principle of equal treatment in relation to access of employment, working conditions and training, the implementation of equality and inclusion varies in different contexts owing to different interpretations of these principles, perhaps explaining why there continues to be a substantial lack of female representation in positions of executive management and decision-making [18].

Women constitute almost 78 percent of the health workforce; however, the majority of female posts relate to the operations side of healthcare [25]. While women have a central role in the delivery of healthcare, their representation in positions of greater responsibility and decision-making is very limited [26], suggesting that to advance gender parity in leadership positions in

healthcare it is imperative that workplace equality and inclusion practices are infused into the workplace culture. In sum, there is quite a growing body of literature on the female-male workforce ratio and the gender wage gap as measures of gender equity, we would be interested to find out more from the systematic review about the impact of culturally sensitive approaches to inclusive work practices which are often less researched.

Inclusive and strategic leaders try and get the best of their followers so that the organization can reach its goals and objectives. Transformational leadership calls for collaboration and engagement amongst healthcare colleagues and a two-way approach in terms of communication. These behaviours can lead to greater sense of well-being amongst team members, which in turn leads to more effective outcomes for service users. Interestingly, when examining workplace practices concerning equality and inclusion in healthcare much less attention is given to these issues amongst healthcare staff in contrast to service users, where inequalities in health-care delivery is well researched [27]. Thus, this paucity in the research on equality and inclusion workplace practices supporting workforce integration in the delivery of health services must be addressed. Specifically, organizational leaders in healthcare must deliver a more culturally sensitive, inclusive environment to retain medical personnel, enhance job satisfaction and increase organizational commitment. Practitioners in the healthcare industry must be encouraged to examine their own cultural biases and behaviours as a foundation for progressing toward becoming culturally competent both in individual practice and at an organizational level [13].

It is imperative that all health care systems worldwide have workforce integration, which is conditioned by egalitarianism and intercultural understanding [15] that incorporates principles of pluralism, equality and inclusion so that future healthcare needs can be catered for by native

and international health professionals working side by side. The growing responsibility of healthcare organizations to design systems that target equality and inclusion practices for their employees requires a sound evidenced based approach in the development process. *Thus, the research question of this study is: what is the current best evidence relating to workplace equality and inclusion practices in healthcare*?

Methods and analysis

This study uses the PRISMA-Reporting guidelines [28]

Study Design

To summarize workplace equality and inclusion practices in healthcare we use the Population, Intervention, Comparison and outcome (PICO) framework to facilitate the literature search.

- In the [population] segment we are concerned with identifying equality and inclusion practices amongst the healthcare employees.
- In the [Intervention] aspect we assess what promotes equality and inclusion amongst practitioners compared [Comparison] to exclusion and inequality.
- The outcome seeks to focus on enhanced inter-professional collaborations, teamwork and engagement in the organization, equality of access across the different areas and levels of healthcare for CPD and career advancement.

Inclusion/exclusion criteria

We will include studies that satisfy all of the following criteria:

1 Studies that describe workplace equality and inclusion practices in healthcare.

2 Studies that focus on equality and inclusion workplace practices that relate to workforce integration, inter-professional collaborations, teamwork, engaged workforce.

3 Studies which discuss the cultural context of healthcare with respect to the impact of the culture on equality practices. It is important to note gender could be a variable that impacts on work culture, however other elements of culture (such as the belief system of the employee/communication patterns) must be considered too to ensure all healthcare employees feel included in the organization.

4 Given that the momentum for equality and inclusion has occurred since the late 2000, studies from 2010 onwards are included in this systematic review.

We will exclude papers where any of the following apply:

1 Studies that describe equality and inclusion from a service user perspective as the focus of this work is on workplace equality and inclusion practices.

2 Reviews, Letters, and personal correspondence.

3 Articles in a language other than English.

Search methods

Studies will be identified by searching the medical literatures using Medline (Pubmed & Ovid), Business Source Complete, Cinahl Complete, Embase, PsycINFO and Scopus to identify primary articles reporting on workplace equality and inclusion practices in healthcare. We will utilize different combinations of the Boolean phrases outlined in Table 1 to identify current best evidence relating to workplace equality and inclusion practices in healthcare.

Table 1 Boolean phrases

Equality AND Inclusion; Equality AND Inclusion AND Healthcare; Staff Equality AND Inclusion AND Leadership/ Professional Development/ Training and Development/ Staff Development/ Mentoring; Healthcare Employees AND Equality AND Culture.

Additionally, citation lists of previous protocols (relating to workplace equality and inclusion in healthcare) and the reference list of papers identified in the above search will be reviewed to ensure all relevant medical literature is captured in evaluating the evidence regarding workplace equality and inclusion practices in healthcare.

Moreover, it is important to note too we will utilize Google Scholar as a control to ensure all relevant literature is detected in relation to workplace equality and inclusion practices in healthcare.

Study Timeframe

Anticipated Start Time: March 2023

Anticipated End Date June 2023

Patient and Public Involvement

No patient or public are involved in this study.

Study selection and Quality appraisal

Firstly, the titles, abstracts, and key words of all the selected medical literature will be read by two members of the team to ensure these works are relevant to workplace equality and inclusion practices in healthcare. The inclusion principles outlined above will guide the reader's decision-making process in ensuring the literature is within the scope of this research project. Papers that do not centre on workplace equality and inclusion practices in healthcare are removed from the process. To ensure a fair, balanced and transparent approach is employed in

the study selection process, a third reviewer is available to consult should they be differences of opinion between the primary readers as regards what literature should be included or excluded in the process.

Following this, the full text of the relevant literature will be read in detail to ensure it is within the scope of this study. It is important to note the third reviewer is always available to discuss should there be divergences of opinion between readers one and two as it is crucial that all eligible relevant works are incorporated in evaluating workplace equality and inclusion practices in healthcare.

Finally, all stages of the study selection process (identification; screening; eligibility and inclusion) will be outlined in a flow diagram (i.e., preferred reporting items for systematic reviews and meta-analyses – PRISMA).

Analysis

Thematic analysis will be employed to evaluate and appraise the data in relation to the following themes:

- Motivation for assessing workplace equality and inclusion practices in healthcare
- Definition of equality and inclusion principles
- A review of how equality and inclusion is measured.
- Discussion on how we can promote and advance equality and inclusion practices.

Ethics and dissemination

Ethical approval is not required. In terms of dissemination, the focus of summer 2022 is to publish both a protocol and a systematic review of workplace equality and inclusion practices in the healthcare sector.

Author contributions

SNL, NR and RL conceptualized the study together. All authors engaged in research to support the writing of the paper. SNL compiled the research in the form of the protocol paper. NR and RL proof-read and edited the paper.

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Competing Interests Statement

None

Data Sharing Statement

No primary data has been collected for the purposes of this paper.

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Supplementary File 1

Search Strategy for all Databases

1 Significant consultations with

(A) Librarian, Learning and Engagement Kemmy Business School, Mr. Peter Reilly and

(B) Librarian, Health Research Methods, Ms. Liz Dors

regarding relevant Databases and appropriate Boolean Terms.

2 Databases that needed to be screened for this study:

A Cinahl Complete

B Embase

C PsycInfo

D Scopus

E Medline (Pubmed & Ovid)

F Business Source Complete

G Google Scholar

3 After consultation with the above librarians, the following Boolean Terms were utilized in the above search engines:

A Equality and Inclusion

B Equality and Inclusion and healthcare

C Staff Equality and Inclusion and leadership

D Staff Equality and Inclusion and Professional development

E Staff Equality and Inclusion and training and development

F Staff Equality and Inclusion and staff development

G Staff Equality and Inclusion and mentoring

H Healthcare Employees and Equality and Culture

Note: (1) In the above search, the word "and" is utilized to ensure all search engines cover *all search terms simultaneously*, for example equality and inclusion. This is a vital step in the process as excluding the word "and" means articles relating to equality are included only.

4 Filters

The following filters were applied in the above search engines:

A Publication Date (2010-2022)

Note: *The researcher could customize the dates, meaning the end date is the most recent (3rd November 2022)*

B Article Type – peer reviewed articles

5 Additional Filters

Limited to English language

6 Saving Citations

Citations will be saved to Endnote

Note: *The researcher can eliminate duplication of file*

Reporting checklist for protocol of a systematic review and meta analysis.

Based on the PRISMA-P guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the PRISMA-Preporting guidelines, and cite them as:

Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart LA. Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 2015 statement. Syst Rev. 2015;4(1):1.

		Reporting Item	Page Number
Title			
Identification	#1a	Identify the report as a protocol of a systematic review	1
Update	#1b	If the protocol is for an update of a previous systematic review, identify as such	N/A

Registration			
	#2	If registered, provide the name of the registry (such as PROSPERO) and registration number	380179
Authors			
Contact	#3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	1
Contribution	#3b	Describe contributions of protocol authors and identify the guarantor of the review	13
Amendments			
	#4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	N/A
Support			
Sources	#5a	Indicate sources of financial or other support for the review	12
Sponsor	#5b	Provide name for the review funder and / or sponsor	1/13
Role of sponsor or funder	#5c	Describe roles of funder(s), sponsor(s), and / or institution(s), if any, in developing the protocol	N/A
Introduction			

Rationale	#6	Describe the rationale for the review in the context of what is already known	2/4
Objectives	#7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	10
Methods			
Eligibility criteria	#8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	10-12
Information sources	#9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	11-12
Search strategy	#10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	See Search strategy supplment
Study records - data management	#11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	N/A
Study records - selection process	#11b	State the process that will be used for selecting studies (such as two independent reviewers) through each	12

		phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	
Study records - data collection process	#11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	13
Data items	#12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	
Outcomes and prioritization	#13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	N/A
Risk of bias in individual studies	#14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	12
Data synthesis	#15a	Describe criteria under which study data will be quantitatively synthesised	N/A
Data synthesis	#15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I2, Kendall's τ)	N/A

Data synthesis	#15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	N/A
Data synthesis	#15d	If quantitative synthesis is not appropriate, describe the type of summary planned	N/A
Meta-bias(es)	#16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	N/A
Confidence in cumulative evidence	#17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	N/A