University of Essex

A Rapid Review on the Success Factors for Mobilising Personalised Care with Frail Older Adults

For: Aging Well Stewardship team -Mid and South Essex NHS foundation trust

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1. Executive Summary

This rapid review provides an overview of the evidence around the factors that influence successful cultural change that ensure the mobilisation of personalised care plans for frail older adults or older adults with multiple morbidities. This rapid review has been produced for the Aging Well stewardship team developed by the Mid and South Essex Health and Care Partnership.

This review involved a systematic search for academic research that address the question: *what factors influence a team's success in implementing personalised care plans for frail older adults with frailty and other long-term conditions?* Ten studies published since 2014 were analysed. The search strategy, inclusion and exclusion criteria are detailed in the methodology section.

The rapid review reports on the factors discussed in the studies for successful change to implementing personalised care and using person-centred approaches. These factors are **(1) planning and goal setting, (2) monitoring and evaluation, (3) inclusivity in care, (4) training and development, (5) adaptability and flexibility of services, (6) use of a biopsychosocial model, and (7) provision of resources.**

Most of these factors can be implemented to support staff members adopt personalised care in their everyday work. This review may also interest future research aimed to investigate the most effective factors and how to operationalise the success factors in different contexts, including a cultural change in personalised care for frail older adults.

2. Introduction

The prevalence of frailty adds to the global burden of disease and is associated with a higher cost on healthcare (Liotta et al., 2018). Frailty is the result of a gradual decline in the individual's physical functional ability in ageing and would, therefore, worsen over the life course (Hoogendijk et al., 2019; Liotta et al., 2018). Nevertheless, it can be delayed through numerous activities (e.g., physical activity) and healthcare provisions. There is a consensus in the literature and in guidelines that personalised care using a person-centred approach is essential and is a better way to meet the needs of people with long-term conditions including frailty

(Edvardsson et al., 2017; Liotta et al., 2018; NHS England, 2015). It is particularly suited for older adults with multiple medical conditions and psychosocial factors such as loneliness and anxiety (Corry et al., 2021; Edvardsson et al., 2017; NHS England, 2015). This model of care, therefore, allows for the treatment of the person as a whole (Corry et al., 2021), where every aspect of the individual's quality of life is considered.

Personalised care plans aims to concurrently coordinate the treatment of multiple morbidities co-existing with psychosocial factors. Hence, this complexity requires versatile staff and care managers to manage these diverse simultaneous care systems involved (Coulter et al., 2013). For this reason, the successful implementation requires a cultural change by teams in favour of it. To establish such a change necessitates adequate preparation by managers, health professionals and carers. Though the personalised care model is gaining momentum in the United Kingdom (UK) and is seen as an essential part of healthy ageing (Cesari et al., 2022), what contributes to its successful implementation is less known, especially in the context of care for people with frailty and other long-term conditions.

2. Aim and Research Question

The Mid and South Essex Health and Care Partnership has developed six stewardship teams from diverse health and care professionals to steward the partnership's resources within their service. The partnership has commissioned the School of Health and Social Care at the University of Essex to conduct a rapid appraisal of applied health research that support the stewardship teams in their decision-making. These reviews aim to synthesis the evidence from the peer-reviewed and grey literature relating to healthcare services raised by the stewardship teams.

The stewardship team focused on the Aging Well services has asked the University of Essex to undertake a rapid review to identify and synthesize relevant published research and evidence around successful cultural changes that ensure the mobilisation of personalised care plans for frail older adults or older adults with multiple morbidities. This review, therefore, examines the following question: *what*

factors influence a team's success in implementing personalised care plans for frail older adults with frailty and other long-term conditions?

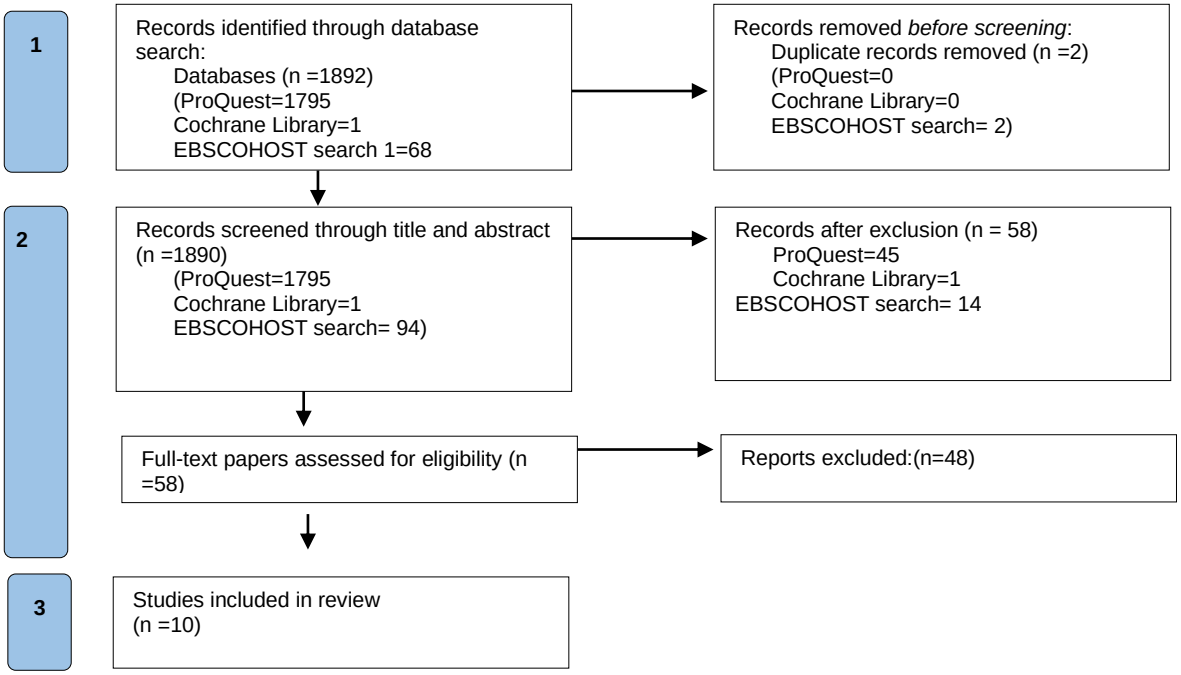
Success factors in this vein refer to measures needed to meet the care needs of older people with frailty and other long-term conditions through personalised care programmes and person-centred approaches. Nevertheless, the focus of this review is to consider the factors and influences on teams and staff members to achieve a successful cultural change to care.

3. Methodology

Rapid reviews are a quick approach to gathering literature and evidence in a way that is time-efficient, pragmatic, and systematic. A rapid review was preferred to a traditional systematic review due to the short timeframe agreed with the Mid and South Essex Health and Care Partnership to complete the research. The rapid review methodology used adhered to the Cochrane Rapid Reviews Interim Guidance (2020) from the Cochrane Rapid Reviews Methods Group and was agreed with the relevant stewardship team. It also followed the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guideline (see Figure 1). The search strategy was documented in a protocol that was agreed with the stewardship team.

3.1 Search strategy

The search strategy examined key health and scientific literature using a combination of MeSH (Medical Subject Headings) terms and keywords that were developed, and search terms were generated (See appendix 1). Three databases were searched: Cochrane Library, ProQuest, and EBSCOHOST (including CINAHL, Medline and PsycInfo).



Note: 1 – identification; 2 – screening; 3 – included

Figure 1. The PRISMA guideline used for the review

3.2 Study Selection

Studies for review were selected first by reviewing the titles and abstracts of the records found in the search. Subsequently, the selected abstracts then underwent a full paper review against the agreed exclusion and inclusion criteria that were discussed and agreed with the relevant stewardship group. The review applied the following inclusion criteria: (1) studies focused on older adults with frailty or long-term conditions; (2) published recently (3) reported findings based on data from the UK; (4) written in English; and (5) published in peer-reviewed journals or relevant grey literature outlets. The initial search of the literature identified 1,892 records in total across the searches described above. The databases automatically removed some duplicates. Further duplicates were removed manually by the researchers. The remaining studies' title and abstract were, then, reviewed resulting in 39 papers. These were reviewed as full papers. During the full paper review, 29 additional papers were rejected. A total of 10 papers were included in this review (see Figure 1).

3.3 Data extraction

Data in the form of study characteristics such as the study design, study objectives, population, sample, findings or narrative findings, and limitations of the study were reported in the data extraction form. A template of this form developed by the reviewers was filled.

3.4 Quality assessment

The papers included were appraised using the Critical Appraisal Skills Programme (2022) (CASP) checklist for systematic reviews and qualitative research. This checklist was used because it has recommendations for all research design types, including reviews (Nadelson & Nadelson, 2014). A first reviewer (JAJ) first assessed the papers independently, and 10% of the articles were later assessed by a second reviewer (NA). The assessment indicated the satisfactory quality of the 10 studies or papers reviewed; each study met at least 90% of the items on the checklist (see Appendix 2).

3.5 Data synthesis and analysis

Since the articles reviewed were heterogeneous, a narrative analytical method utilised in a previous review (Luscombe et al., 2017) was employed. This analysis involved tabulating attributes of reviewed papers (see Table 1) as well as key findings relating to the research question. In harmony with the research aim, a table showing all success factors reported by each paper or study was created (see Table 2). The most consistent and frequently reported factors were then identified. A key aspect of the analysis was a comparison of the consistent factors highlighted by the ten studies and how they relate to the less frequently reported factors. All these factors were reviewed based on how they may influence a successful cultural change in personalised care for frail older adults.

4. Findings

4.1 Characteristics of studies

Six (6) of the studies utilised data exclusively from the UK, and four (4) combined data from the UK and other countries. Four (4) studies were systematic reviews, 2 were qualitative studies, 1 was a secondary document review, 1 was a realist synthesis, 1 was a conceptual paper, and 1 was a realist review. The studies focused on older people with frailty, people with long-term conditions (e.g., dementia), and older adults with complex health and social care needs. All, but one study, were published around 2016 onward with more than half (n=6) published in the last five years. This could be an indication that this a topic of emerging interest. Table 1 shows the above characteristics as well as other relevant attributes of the reviewed studies.

Table 1. Summary of the included papers

No.	Author(s)	Date	Study design	Population	Sample size	Country
1	Chenoweth, L. et al.	2019	Systematic Review	People with dementia	12 studies	UK and other countries
2	Ellis-Smith, C. et al.	2021	Systematic review	People aged ≥65 years living with advanced or life-limiting condition(s), including cancer and chronic non-cancer conditions, and nearing end of life	44 articles	UK and other countries
3	Sleeman, K. et al.	2021	Document analysis/review	Palliative and end of life care	15 policy documents	UK
4	Sadler, E. et al.	2019	Systematic review	Older people with frailty, carers, and providers	18 studies	UK and other countries
5	D'Avanzo, B. et al.	2017	Systematic (Meta) synthesis	Frail older adults or stakeholders involved in their care (e.g., nurses, allied health professionals, family caregivers)	45 studies	UK and other countries
6	Corry, A. et al.	2021	Qualitative study	Key health professionals in the aged care field	16 participants (n=7 from Republic of Ireland and n=9 from Northern Ireland)	UK and the Republic of Ireland
7	Bunn, F. et al.	2018	Realist synthesis	Community dwelling older people with complex health and care needs (people with frailty, multi-morbidity, and long-term conditions)	26 evidence reviews, 46 primary research studies, 7 guidelines, cases studies or reports, and 9 discussion/opinion papers.	UK
8	Bunn, F et al.	2017	Realist review	People living with dementia, diabetes, and/or frailty.	89 papers	UK
9	Gridley et al.	2014	Qualitative study	Young adults with complex or life-limiting conditions; adults with brain or spinal injury and complex needs; older people with dementia and complex needs	67 participants (People with complex needs =22; family carers = 23; members of organisations =22)	UK
10	Hunt, k.	2016	Conceptual paper	People with frailty	NA	UK

Note: NA – not applicable; UK – United Kingdom

Table 2. Success factors and key limitations identified in the rapid review

Author(s)	No.	Factor(s)	Limitation(s)
Chenoweth et al. (2019)	1	(1) Developing knowledge through training for direct care staff and care managers; (2) Person-Centred Care (PCC) skills modelling by champions/coaches; (3) PCC supervision by champions/coaches; (4) specialised leadership at the systems level; (5) Learning how to apply person-centred care; (6) PCC planning in consultation with frail older service users and their families, and (7) encouragement of families to participate in PCC.	(1) There was a difference in measurement points across studies; (2) The measures of the most used primary outcome only were analysed; (3) The review included studies with moderate to high risk of bias
Ellis-Smith et al. (2021)	2	(1) Utilization of tools that target comprehensive assessment and continuity of care, and (2) training on how to act.	(1) Decisions about the interventions were unavoidably subjective; (2) Differences in the strength of the evidence and the risk of bias across studies
Sleeman et al. (2021)	3	(1) Allowing people to shape their care according to their preferences and choices, and (2) support planning	(1) It did not include policy document produced by professional bodies, charities, and regulatory organisations
Sadler et al. (2019)	4	(1) Effective management of relationships between key actors (e.g., service user, care providers, families)	(1) Relevant papers may have been missed in the search strategy; (2) Studies focused on a single long-term condition were removed
D'Avanzo et al., (2017)	5	(1) Optimum capacity; (2) involving families; (3) allowing patients to make choices based on personal preferences; (4) effective relationship between stakeholders; (5) quality of communication; (6) adaptability of services and systems to the needs of frail older service users; (7) flexibility in services and systems (e.g., allowing relatives to stay overnight); and (8) allowing older adults to make choices that influence their care	(1) Reviewed studies were based on different methodological designs; (2) Included studies had some methodological weaknesses
Corry et al. (2021)	6	(1) Cultural change; (2) moving away from the medical model (i.e., treating the condition) to the biopsychosocial model (i.e., treating the whole person); (3) availability of time; (4) availability of funds; (5) availability of staff; (6) educational changes that provide relevant skills on a professional development pathway, and (7) effective integration of stakeholders	(1) The use of a snowball sampling method limits generalisability; (2) Professionals were not directly involved in the feasibility aspect of the intervention
Bunn et al. (2018)	7	(1) An understanding of the needs of frail older service users, families, and carers; (2) understanding the values of the carer and service user; (3) cultural change; (4) availability of time; (5) availability of resources; (6) trust among stakeholders; (7) support for professionals, and (8) adaptability of services	(1) There was no comparative evidence on the management of complex care needs or the needs of people with long-term conditions
Bunn et al. (2017)	8	(1) Planning in a person-centred way; (2) developing skills to provide tailored care; (3) training staff to achieve service flexibility; (4) monitoring by carers and managers; (5) trust among stakeholders, and (6) empowerment through training; (7) staff's understanding of the trajectories of long-term conditions, and (8) staff's ability to meet changing needs	(1) There was no evidence on the management of diabetes, which made it impossible to compare outcomes with existing evidence
Gridley et al. (2014)	9	(1) Use of the biopsychosocial model; (2) integrated delivery or integration of care to include all stakeholders; (3) availability of continuous support for staff and frail older service users; (4) availability of resources; (5) service flexibility; (6) timeliness of care and actions; (7) specialist expertise; (8) specialist information; (9) effective communication between actors; and (10) dedicated support to organise multiple services	(1) Potential participants who lack capacity could not participate
Hunt (2016)	10	(1) Effective planning	---

Note: PCC – person-cantered care

4.2 Results

Table 2 shows the reported factors for successful change identified in the review as well as limitations in each study. Each paper reported at least one success factor, and most papers reported more than five factors. The largest number of factors was reported by Gridley et al. (2014). In the narrative analysis, the following factors emerged: (1) planning and goal setting (n= 4), (2) monitoring and evaluation (n=2), (3) inclusivity in care (n=4), (4) training and development (n=4), (5) adaptability and flexibility of services (n=4), (6) use of a biopsychosocial model (n=2), and (7) provision of resources (n=3). These factors were identified using the first two steps of thematic analysis (Marincowitz et al., 2022). This procedure involved creating a transcript of the findings extracted and uploading the transcript to NVivo 12, which automatically generated the factors (themes) and mapped them onto the text for each study in the transcript. The mapped text was used to create Table 2.

4.2.1 Planning and goal setting

Four studies (Chenoweth et al., 2019; Bunn et al., 2017; Hunt, 2015; Sleeman et al., 2021) reported effective planning and goal setting as the foundation for the mobilisation of personalised care. The papers recounted that without planning and setting of goals, a programme of personalised care for older people with frailty is likely to result in confusion among carers, poor stakeholder involvement, and low service user quality rating. However, as important, three of the studies (Bunn et al., 2017; Chenoweth et al., 2019; Hunt, 2015) emphasised a need for “specialised planning”, a term referring to holistic planning to meet the care needs of people with frailty and long-term conditions. This includes involving key stakeholders (i.e., service users, families, carers, managers of care) in setting goals to meet the foregoing needs. There is a consensus among these studies that traditional or integrated care planning may not produce the desired results in personalised care because it does not focus on individual needs and weakly integrates families and other stakeholders. Bunn et al. (2017) describe “specialised planning” as a process drawing on an understanding of the evolving needs of older service users to set

goals for meeting individual needs while involving families, carers, and managers. “Support planning” has been reported by Sleeman et al. (2021) as an essential component of planning for a successful cultural change and the delivery of high-quality personalised care. As a facet of specialised planning, support planning is focused on setting goals to support exclusive groups, namely service users (i.e., frail older adults) and carers. Though support for service users is the priority of all personalised care, the importance of support for carers and other staff member over time has also been acknowledged (Bunn et al., 2017). Sleeman et al. (2021) reasoned that support to improve job knowledge and skills, as well as carers’ satisfaction, is essential for sustaining a programme of personalised care that is well suited to trajectories of long-term conditions including frailty and neurodegenerative disorders (e.g., dementia). Planning, regardless of its form, is also necessary for effective monitoring and supervision, which is another important success factor reported below.

4.2.2 Monitoring and supervision

Two studies (Bunn et al., 2017; Chenoweth et al., 2019) reported a need for routine monitoring and supervision as an essential success factor for a cultural change in provision of personalised care for older adults with frailty. As an activity informed by planning, supervision and monitoring should be as unique and specialised as possible, ensuring that service providers can adapt to the conditions of service users as they change over time (Bunn et al., 2018; D’Avanzo et al., 2017). In this sense, monitoring and supervision are intended to ensure that care is being optimally provided and to oversee the performance of the carers and other staff members. This means that planning ought to recognise how carers align their professional development goals and priorities with the evolving needs and expectations of service users and their families. Traditionally speaking, though, managers are responsible for supervising, ensuring that the right care model (e.g., a psychosocial care model) is implemented with flexibility allowing for changes in trajectories of frailty and other long-term conditions (Bunn et al., 2018). The manager’s supervisory role should support the family’s involvement in care and ensure that service users share their satisfaction with their families and acquittances (Bunn et al., 2018).

Monitoring of care is closely tied to supervision in practice in the sense that deviations from agreed care plans and expected outcomes (e.g., quality, satisfaction) cannot be identified and mitigated without the two running concurrently, often within the same managerial team (Bunn et al., 2017; Chenoweth et al., 2019). Supervision is relevant to successful quality care delivery as it prevents or eliminates systematic errors and encourages carers to observe standards and values in personalised care (Sleeman et al., 2021). Monitoring, which is led by care managers (Bunn et al., 2017), tracks sustained adherence to the specialised plan, agreed standards, and professional values while reminding carers to avoid errors and consistently follow best practice. It is also aimed at identifying errors and issues as early as possible, to best support risk mitigation.

The activity logs and short-term reporting and archiving generated as part of monitoring and supervision can input into data for care or process audit and evaluation (Bunn et al., 2018; Sleeman et al., 2021). Effective supervision and monitoring that provides information for process audit and evaluation can support success in the mobilisation of personalised care for people with frailty. More so, monitoring of service users and their families by the carer is necessary to assess the effectiveness of support and care (Bunn et al., 2017). Whether a personalised care programme for frail older adults would be successful depends on how well carers monitor specific care activities as well as potential changes in the conditions being treated to know if plans, actions, and medications are producing the expected results. Thus, supervision of carers by managers and monitoring of service users by carers are distinct success factors for mobilising personalised care for frail older adults. This being so, effective supervision and monitoring is relevant to any programme of personalised care, including a programme requiring a cultural change towards personalised care. As analysed below, these factors could be more significant in a model of inclusive care.

4.2.3 Inclusivity in care

Another frequently reported success factor for mobilising personalised care for frail older adults is being inclusive in the provision of care (Chenoweth et al., 2019; Gridley et al., 2014; Sleeman et al., 2021; Sadler et al., 2019). The hallmark of this

approach is including all stakeholders (i.e., service users, carers, managers, families) in the provision of care and allowing service users to shape their own care plans. Service users and their relatives have expectations and needs that change with their long-term conditions over time, and the ideal way to meet these evolving needs is to allow service users to articulate their preferences and choices (Chenoweth et al., 2019; D'Avanzo et al., 2017; Sleeman et al., 2021). This means that planning and execution of a cultural change for or in personalised care should actively include service users and their families. This model includes adapting services, if necessary, to meet service users' preferences while consulting all stakeholders including service users and their families. These reveal a related important success factor, service flexibility and adaptability, which emerged in four papers (Bunn et al., 2017, 2018; D'Avanzo et al., 2017; Gridley et al., 2014).

Service adaptability refers to changing care plans and activities to meet the emerging needs and conditions of service users (Bunn et al., 2017; Gridley et al., 2014). Like the other factors, service adaptability is important because service users with potential co-morbidities have a fragile physiology and health status that is likely to change over time. People's evolving needs explains why the planning of personalised care for frail older adults must recognise a need for flexibility and must create opportunities for changing services that are not limited by time and resources. Adaptability also concerns carers' understanding of trajectories for long-term conditions and care-oriented interventions to these trajectories. The core of service flexibility is creating opportunities for service users and their families to change their expectations in response to their evolving circumstances without reducing the quality of the care they receive. D'Avanzo et al. (2017) emphasised this when they acknowledged a need for allowing a longer care schedule and permitting family members to stay with their service users overnight. Carers and managers must be supported through training to achieve optimum adaptability of services, see next section.

4.2.4 Training and development

Four studies (Bunn et al., 2017; Chenoweth et al., 2019; Ellis-Smith et al., 2021; Corry et al., 2021) identified training and development of carers, health care staff,

and managers as a critical success factor, arguing that training aligns existing expertise with a personalised care plan or equips professionals with new sets of skills for implementing this plan effectively. So, a cultural change in personalised care would require new expertise to be acquired through relevant training. Even if carers and managers are well experienced in the delivery of personalised care for older people with frailty, a need for their continuous training and development is evident (Corry et al., 2021). This can be said given the evolving needs and conditions of service users and a need for professionals to meet the care demands of these changes, regardless of how often the changes occur. It can, therefore, be inferred that the frequency of training would depend on how individual conditions and needs develop. Ideally, care plans should include and dictate the continuous training and development of professionals over the entire lifecycle of any programme adopting personalised care (Bunn et al., 2017; Ellis-Smith et al., 2021).

Also mentioned as a success factor alongside training and development is continuous learning (Chenoweth et al., 2019), which occurs on the job and in training programmes, apprenticeships, or formal education. Regardless of how it occurs, continuous learning is considered necessary for avoiding the repetition of systematic errors, enhancing the ability to meet changing needs, and serving as a champion, mentor, or supervisor in future. While the literature provides no information about the best way to enforce learning, training programmes may serve as an avenue for conscientizing carers to learn on the job or through a self-didactic pathway. Enhancing learning through apprenticeship and mentorship programmes as well as continuous formal education has also been acknowledged (Bunn et al., 2017; Chenoweth et al., 2019; Ellis-Smith et al., 2021), but this step depends on the availability of resources as indicated as follows.

4.2.5 Availability of resources

Three studies (Bunn et al., 2018; Corry et al., 2021; Gridley et al., 2014) identified the availability of resources as an important success factor for a cultural change in personalised care for frail older adults. Resources in these papers include staff (i.e., carers, managers of care), finances, time, and other equipment that facilitate personalised care, but carers, funds, and time are more prominent success factors in

the literature. Even so, carers are only considered a resource if they are well-skilled to support personalised care for frail older adults, which emphasises the role of training in developing personalised care staff. Funds, like human resources (e.g., carers), are important resources for staff compensation, purchase of equipment and tools, and meeting various administrative costs incurred during person-centred care. Managers, civil society organisations, philanthropists, and relevant trusts are identified as key funders of personalised care and stakeholders responsible for the effective management of resources. Managers, through monitoring, supervision, and financial audits (Bunn et al., 2017), are responsible for optimising the value of funds and ensuring accountability and transparency in the way resources are used. As such, a personalised care programme or any change in favour of it would require adequate resources and their effective management.

Another outstanding success factor reported is effective use and availability of time. Three papers (Bunn et al., 2018; Corry et al., 2021; Gridley et al., 2014) agree that time can be a scarce commodity in personalised care for frail older adults and that its availability and effective use can mean the difference between success and failure in mobilising personalised care for older adults with long-term conditions. Some papers (Bunn et al., 2018; Corry et al., 2021) have provided key recommendations for effective time use and management, which are (1) developing timelines of care and incorporating this into care plans; (2) indicating those who are to take specific actions and the maximum time allowed for these actions; (3) monitoring carers to work within schedule both for the short and long-terms, and (4) meeting service users' time expectations. The fourth recommendation draws on the idea that patients' quality perceptions are influenced by how early their needs are addressed and met (Sadler et al., 2019; Gridley et al., 2014). Yet, patients' quality ratings are further influenced by the model of care used as analysed below.

4.2.6 Focusing on the biopsychosocial model of care

Two papers (Corry et al., 2021; Gridley et al., 2014) reveal that the biopsychosocial model, as opposed to the medical model, is more suited to personalised care for frail

older adults. The medical model, which has been portrayed as an out-of-date approach, aims to treat patients' conditions (i.e., frailty, dementia), overlooking psychosocial conditions faced by the patients (Corry et al., 2021). Frail older adults are generally within the oldest-old group (i.e., people aged 80 years or higher) who face multiple morbidities, including psychosocial disorders (e.g., loneliness, anxiety), and physiological limitations. As such, services focused on medical conditions undermine many of the individual's additional problems or experiences that obliterate their quality of life. Furthermore, underlying psychosocial conditions may be independent of the medical conditions being treated, so frail older adults may not equate the effectiveness of care to the medical model (Ellis-Smith et al., 2021). The biopsychosocial model is more successful in meeting the needs of service users because it treats medical issues and psychosocial influences (e.g., stress, anxiety, depression, worry), giving the patient relief from both medical conditions and unwanted feelings and life experiences (Corry et al., 2021; Gridley et al., 2014). Care cannot be deemed successful if it does not result in patient satisfaction. This model, however, requires more resources (e.g., funds, time), commitment, and an interdisciplinary or versatile team of carers who can treat multiple medical and psychosocial conditions. No doubt, more training is needed by carers to effectively provide services to frail older people. A personalised care programme or a change in culture favouring it would ideally embrace this model.

5. Discussion

This review aimed to identify success factors for mobilising personalised care for frail older adults. The above findings reveal measures that could be taken or considered in the implementation of a personalised care programme or in changing the culture of this programme for frail older adults. The review found several success factors and the most consistent ones were planning and goal setting, monitoring and evaluation, use of an inclusive care approach, training and development of carers and managers, adaptability, and flexibility of services, use of a biopsychosocial model, and provision of resources.

- *Identified success factors are robust*: An assessment of the quality of the reviewed papers produced satisfactory results, which suggests the reliability of the findings reached (Haddaway et al., 2015; Shea et al., 2009). A satisfactory outcome of the quality assessment and the compliance of the review with the Cochrane standard suggest the findings are suitable for application in practice. Stakeholders, for instance, might change the culture of an existing personalised care programme by replacing the medical model with the biopsychosocial model or by making current practices more consistent with this approach. Similarly, the flexibility and adaptability of services could be improved while giving service users more opportunities to influence their care.

- *Relative weight of factors:* Some factors (e.g., training and development of staff, allowing service users to influence their care) were more frequently mentioned in the literature. Even so, less frequently reported factors should not be overlooked or undermined in planning or executing a cultural change since they might play a unique role in personalised care. The literature provides no information about which factors are more important, nevertheless, decision makers may want to prioritise factors of high importance. Future research focused on understanding the relative importance of the factors in the context of culture change may be beneficial to practitioners.

- *Operationalising factors:* There was also no evidence regarding how to operationalise the success factors found in implementing a successful cultural change in the current context. While factors such as staff training and development as well as the use of the biopsychosocial model are outstanding in the literature (Corry et al., 2021; Gridley et al., 2014), the reviewed papers provide no information about how to operationalise them. This shortcoming implies a need for research into how to operationalise the factors in practice, though existing models of the factors (e.g., training and development, biopsychosocial model of care, inclusive model of care) may be adapted.

This review systematically identified the factors that influence a successful cultural change in a personalised care programme for frail older adults and streamlines the

scope of measures and activities that can lead to this change. Most of these factors can be adopted to support staff members assume personalised care in their everyday work. Having revealed the success factors, this review allows future researchers to employ appropriate research designs to investigate what are the most effective factors and how to operationalise the success factors in different contexts, including a cultural change in personalised care for frail older adults. The involvement of families in personalised care in the context of a cultural change has also been emphasised in the literature (Chenoweth et al., 2019; D'Avanzo et al., 2017; Sadler et al., 2019; Bunn et al., 2018).

6. Conclusion

This review identified several success factors for mobilising personalised care and person-centred approaches for people with frailty and other long-term conditions. Among the most frequently reported success factors are effective planning and goal setting aimed at addressing the evolving long-term conditions of older adults and monitoring and evaluating care activities to ensure goals of personalised care are met in the short and long terms. The use of an inclusive care approach where service users, their families, carers, and managers are included in the planning and execution of care is also prominent in the literature. Training of staff to understand and meet service users' needs over time is also a key success factor. The adaptability and flexibility of services, which enables managers and carers to modify the approach to care to better meet the emerging needs and conditions of service users, is consistently reported in the reviewed papers. The use of a biopsychosocial model where the whole person rather than a single medical condition is treated is identified not only as a success factor but also as a hallmark of person-centred care for the population under consideration. Finally, the sustained provision of resources in the form of funds, skilled personnel, and equipment is necessary for the successful implementation of a personalised care programme for people with frailty. The way these resources are utilized for the short and long-term should be based on a planned timeframe within which care is provided.

This review identified the success factors for mobilising personalised care for people with frailty, yet the reviewed papers did not provide enough information to understand how some factors work in practice. For example, little was said about how to implement the biopsychosocial model and how it can be effectively rolled out in personalised care for frail older adults. Future research is needed to understand how to implement this model and other factors effectively.

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Appendix 1

Search terms	Databases
“Personalised care” OR “Assisted living facilities” AND Frailty OR Frail* AND “Older adults” OR “Frail elderly” AND “Long-term condition” OR “Chronic disease” AND “Success factors” OR achievement OR achiev*	Cochrane Library
older adults OR frail elderly OR seniors AND Personalised care plan OR person-centred care plan OR assisted living facilities AND cultural change OR organizational culture AND condition-based intervention OR specialised intervention OR protocol AND long-term conditions OR chronic disease OR multimorbidity AND UK OR United Kingdom OR Britain	ProQuest
Search 1: older adults or elderly or seniors or geriatrics AND Personalised care plan OR person-centred care plan OR assisted living facilities AND UK or United Kingdom or Britain or England or Wales or Scotland or Northern Ireland Search 2: older adults or elderly or seniors AND "Personalised care plan" OR "person-centred" care plan AND UK or United Kingdom or Britain or England or Wales or Scotland or Northern Ireland Search 3: Personalised care plan OR person-centred care plan AND older adults OR frail elderly OR seniors	EBSCOHOST (PsycINFO, CINAHL, and MEDLINE)

Appendix 1. Search Terms used in different databases

Appendix 2

Appendix 2a. The results of the quality assessment of studies (excluding papers 6, 9 and 10)

Paper no.	Section A: Are the results of the review valid?					Section B: What are the results?		Section C: Will the results help locally?		
	1. Did the review address a clearly focused question?	2. Did the authors look for the right type of papers?	3. Do you think all the important, relevant studies were included?	4. Did the review's authors do enough to assess quality of the included studies?	5. If the results of the review have been combined, was it reasonable to do so?	6. What are the overall results of the review?	7. How precise are the results?	8. Can the results be applied to the local population?	9. Were all important outcomes considered?	10. Are the benefits worth the harms and costs?
1	YES	YES	YES	YES	Yes	**	**	Yes	Yes	Yes
2	YES	YES	YES	YES	Yes	**	**	Yes	Yes	Yes
3	Yes	Yes	Yes	*	Yes	**	**	Yes	Yes	Yes
4	Yes	Yes	Yes	Yes	Yes	**	**	Yes	Yes	Yes
5	Yes	YES	Yes	YES	*	Yes	Yes	Yes	*	Yes
7	YES	YES	Yes	*	Yes	Yes		yes	*	Yes
8	YES	YES	*	YES	Yes	Yes	Yes	yes	*	Yes

*Not applicable or relevant; **Criterion met or satisfied

Appendix 2b. The results of the quality assessment of studies 6, 9 and 10

Paper no.	Section A: Are the results of the review valid?						Section B: What are the results?			Section C: Will the results help locally?
	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?
6	Yes	Yes	Yes	Yes	Yes	*	**	Yes	**	*
9	Yes	Yes	Yes	**	Yes	*	Yes	Yes	Yes	No
10	Yes	Yes	*	*	*	*	*	*	*	Yes

*Not applicable or relevant; **Criteria met or satisfied