CARE…ABOUT PHYSICAL ACTIVITY (CAPA) IMPROVEMENT PROGRAMME:

PHASE 2 FINAL-EVALUATION REPORT

MARCH 2020

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Executive Summary

Background

The Care Inspectorate is the national scrutiny and improvement support body for social care and social work services in Scotland.

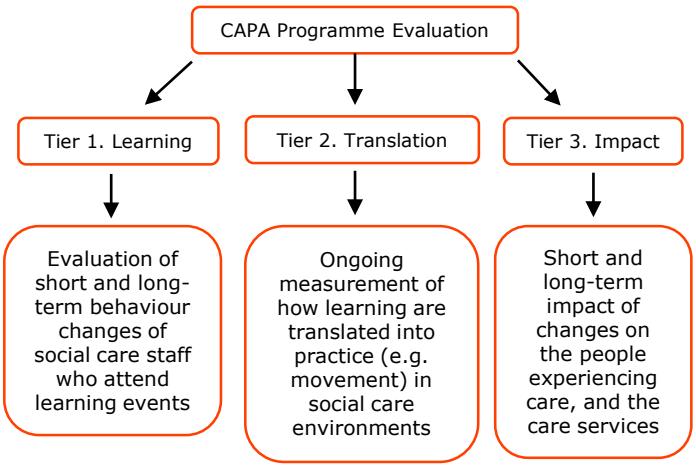
In 2016 the Care Inspectorate was commissioned by the Scottish Government to deliver the Care…About Physical Activity (CAPA) improvement programme which aimed to improve the health and wellbeing, independence, and overall quality of life of older people experiencing care across Scotland. This is done by empowering care staff with the confidence, knowledge and skills to promote and enable opportunities for movement for older people experiencing care.

From 2018-2019 the programme was initially delivered across eight partnership areas, involving up to 140 care services including care homes, reablement, day care, sheltered housing and care at home services. In the second phase, the programme (2019-2020) was expanded to another eleven partnership areas, bringing the total to 19, and including care services in island locations and local hospital wards.

309 care services and over 2,000 social care professionals, among other professionals, participated in the CAPA programme.

Measurement and Evaluation

The evaluation of CAPA utilises a dynamic, flexible, and multi-tiered framework approach to understand and evidence the impact of the programme. This framework includes:



Findings and Discussion

Tier 1. Learning

Two Learning Events (LEs) took place for social care professionals between April and November 2019. These focused on upskilling professionals to enable daily movement in their care services. Data was captured on 'perceptions of movement' and 'confidence to enable movement' through questions, collected pre (before) and post (after) the LEs. Statistical modelling was used to determine the significances of changes.

Prioritisation of movement

At both LEs social care professionals showed statistically significant improvements ($p<0.001$) in how often they reported encouraging movement and how much of a priority they felt promoting movement was in their role, both in the short (pre to post) and long term (LE1 to LE2). The magnitude of improvement was greatest for 'priority of promoting movement'.

Perceptions of movement

All 'perceptions of movement' showed statistically significant ($p<0.001$) improvements in the short (pre to post) and long term (LE1 to LE2). Short term improvements tended to be greater at LE1 than LE2. This was particularly the case for 'feeling qualified to promote movement', 'feeling knowledgeable to promote movement', and 'having confidence to support an older person to move more'. Areas that saw the smallest improvements were around 'having time in ones role to promote movement' and 'having a movement supportive culture'. The latter factors may only see small changes over time because they take longer to become embedded.

Confidence to enable movement

'Confidence to enable movement' showed statistically significant ($p<0.001$) improvements in the short (pre to post) and long term (LE1 to LE2). This suggests that taking part in LEs boosts the confidence levels of social care professionals in the short term by providing them with knowledge, guidance and best practice of how to enable movement. The areas with the greatest improvement included 'confidence to assess an older person's readiness to move', 'take action again barriers that prevent movement' and 'create an active environment for an older person'. Only small changes were seen from LE1 to LE2 indicating that most of the learning is accumulated at LE1.

Social care professionals were most likely to promote and encourage movement through activities of daily living (ADL), independence and personal care. They focused on making small steps and small changes to the daily routines of people experiencing care by listening to their needs. The greatest challenges to enabling movement were a lack of time, resource, or movement positive attitudes from staff.

Tier 2. Translation

Qualitative data collection (focus groups and case studies shared by care staff) was used to understand how learnings were translated into practice.

Knowledge and understanding

Services learnt…

… about how to support those with dementia by encouraging old hobbies or activities of daily living.

… about making small cultural changes centred around routines that already occur.

… to be adaptable to their care service.

… about the importance of support by spreading the message to other staff.

… about developing an evidence-base to improve buy in from staff and families.

Implementation and practice

Services have…

… started to plan activity into care plans.

… become more risk enabling by re-evaluating risks and understanding some are acceptable.

… gone back to the code of practice and aligned practice to the Health and Social Care standards.

… used communication to explain CAPA.

… use the power of leadership to encourage buy in and support.

Sustainability

Services will…

… start small and think big by continuing feasible and realistic changes.

… maintain links with the local community to host activities and build meaningful relationships.

… continue to share best practice with others.

… continue to utilise and build relationships with other care services.

… upskill social care professionals by providing training, mentoring, and peer learning.

Tier 3. Impact

Data collected via questionnaire and physiological tests were used to evaluate the impact of the CAPA programme on the health and wellbeing of people experiencing care.

Physiological & Movement Impact

Physiological data collected through four physiological tests was used to measure the impact of the CAPA programme on the physical health of people experiencing care who took part. Data was collected from up to 254 individuals, aged between 76-96 years. Data was collected every 6-weeks across 6 time points with a baseline for each individual.

No significant changes in hand grip strength across the CAPA programme. → ⟷ **Changes in grip strength fluctuated throughout.**

A significant increase in the length of time people experiencing care could balance on one leg across the CAPA programme ($p<0.001$). → ↑ **Increases in leg balance.**

A significant increase in the number of sit to stands people experiencing care completed across the CAPA programme ($p<0.001$). → ↑ **Increases in leg strength.**

No significant changes in timed up and go scores across the CAPA programme. → ⟷ **No changes in timed get up and go.**

Individuals spent the majority of their time sitting. 1/5 of their time is spent moving. → ⟷ **Moving time fluctuated throughout and was between 4-5 hours per day.**

Collectively, the physiological test scores indicate that people experiencing care had the greatest opportunities to improve their mobility, leg endurance and leg strength. They also show a reduced likelihood of falls and rate of falls per person.

Fall risk & number of falls

Data on falls risk, number of falls and number of medical contacts due to falls was measured, alongside five questions that allowed quality-adjusted life years (QALYS) and health related quality of life (HRQoL) to be calculated.

A significant decrease in fall risk and the total number of people falling over the CAPA programme ($p<0.001$). → ↓ **Reduction in likelihood of falls and rate of falls per person.**

The total number of people experiencing care who had contact with medical services as a result of their falls reduced across the data collected from the CAPA programme. → ↓ **Reduction in contacts with medical services per person.**

The total number of medical service contacts reduced across the data collected from the CAPA programme. → ↓ **Reduction in total number of contacts with medical services.**

QALYs was collected over a period of 0.62 years (across 36-weeks). QALYs was 0.47 years. To have 'perfect health' QALYs has to match of exceed the period of 0.62 years. → ⟷ **People experiencing care were not experiencing perfect health.**

There was a small, significant improvement in HRQoL over the CAPA programme ($p = 0.003$). →

The proportion of people experiencing care who rated their health above 61 increased steadily over the course of CAPA (where 0 = worst health possible imagined and 100 = best health possible imagined). → ↑ **The calculated health related quality of life for people experiencing care improved, as did their perceptions of how healthy they felt.**

Psychological Impact

Focus groups were held with people experiencing care and social care professionals. Psychological impacts have been divided into mental wellbeing and individual development.

"I like to walk – it clears my mind. Doing activity is better than just sitting around doing nothing, that gets so boring."

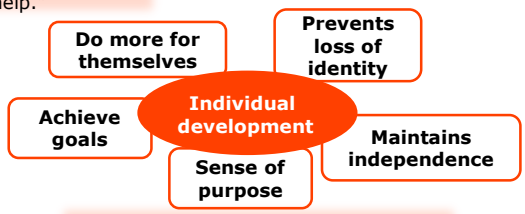
There was a significant improvement in loneliness scores ($p<0.001$), measured through a single-item question, over time for people experiencing care taking part in CAPA.

"I like the feeling after I've done the exercise that I have done it, it makes me feel more satisfied with myself".

There was a significant improvement in perceptions of feeling part of ones community over time for people experiencing care taking part in CAPA ($p<0.001$) .

"I feel like I can do more things by myself. Now I walk down the corridor instead of use my Zimmer and don't have to wait for help."

"I would lose my identity and confidence if I couldn't do things by myself. I am still here and thinking"



Doing activities that mattered to people experiencing care significantly improved across the delivery of CAPA ($p<0.001$). This was measured through a question about sense of purpose.

Conclusion & Recommendations

The CAPA programme model was able to fulfil its aim of making changes to the movement, wellbeing, independence and quality of life of people experiencing care. The measurement and evaluation framework put in place was successful at capturing data to evidence changes in these factors.

- The responsibility of sustaining CAPA is passed back to care services and partnership areas. It is recommended that services continue to share best practice and support.
- For any further learning and development opportunities for social care professionals it is recommended these adopt similar approaches to those of the CAPA learning event.
- Opportunities for people experiencing care to walk regularly, enhance balance and enhance strength should continue to maintain improvements.
- It is recommended that a similar model be rolled out across other home nations to support UK care services to incorporate daily movement into the lives of people experiencing care.

Background

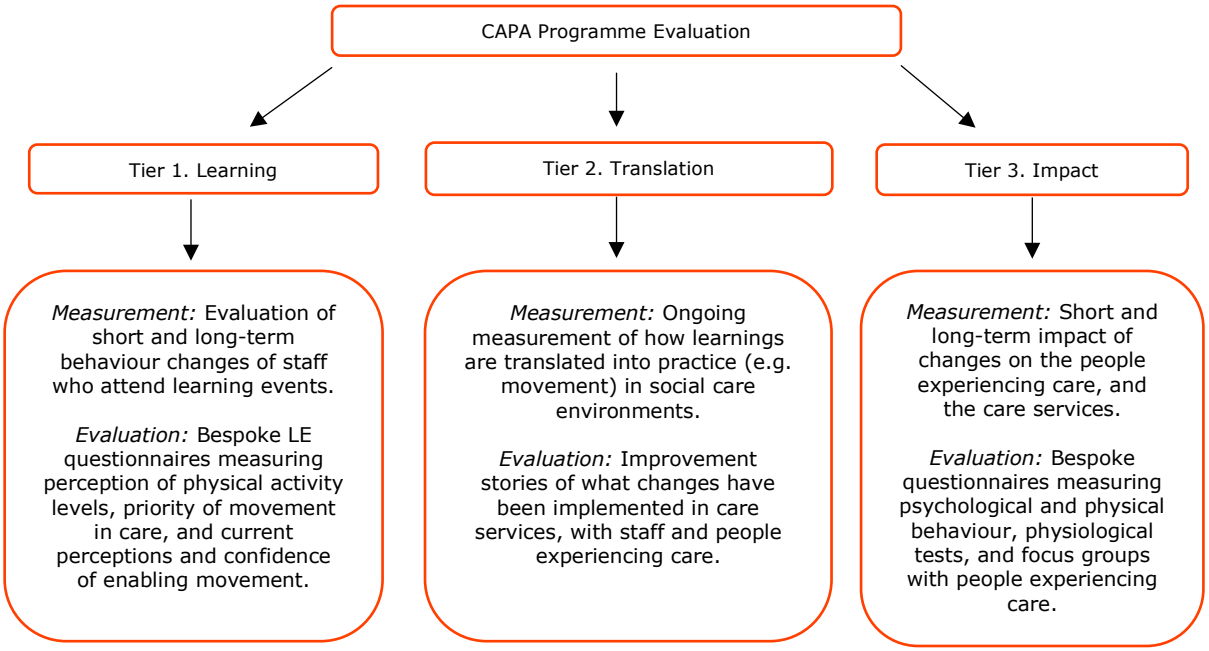
In 2016, the Care Inspectorate was commissioned by the Scottish Government, funded through the Active Scotland division, to design and deliver the 'Care…About Physical Activity' (CAPA) improvement programme. CAPA sought to improve the health and wellbeing, independence, and overall quality of life of older people experiencing care across Scotland. This was achieved through empowering care staff with the confidence, knowledge, and skills to promote and increase movement levels of those experiencing care. CAPA was initially delivered between April 2017 and October 2018, successfully demonstrating improvements in social care professionals' confidence, skills, and attitudes towards enabling movement for people experiencing care, as well as positive physiological and psychological improvements in people experiencing care taking part in the programme (the full evaluation report can be found here[1]).

Based on the success of the initial CAPA programme, the Care Inspectorate received further funding from the Scottish Government to continue the programme, with the second iteration (phase 2) running between January 2019 and March 2020 in 11 partnership areas. Delivery followed the same model as before, while incorporating learnings from the first phase to improve programme quality and engage a wider number of care services across Scotland.

The aim of CAPA is to support care professionals in identifying opportunities for people experiencing care to move more, promoting movement in their services, and developing local networks that support and sustain improvements[2]. The CAPA programme was based on the Institute for Health Care Improvement's Breakthrough series, which sought to improve care through collaborative change at a lower cost[3]. CAPA was developed to bring together relevant stakeholders to learn about, discuss, and apply practical steps to embed movement into care services in a way that facilitates sustainable behavioural change.

Measurement and Evaluation Framework

The ukactive Research Institute are the independent evaluators for the CAPA programme. A dynamic, flexible, and multi-tiered framework approach was developed to understand and evidence the impact of the CAPA programme, utilising valid and reliable outcome measures. This can be seen below.



[1] https://hub.careinspectorate.com/media/1115/capa-evaluation-report-2017-2018.pdf
[2] The CAPA resource pack was originally developed in 2014 by the Care Inspectorate in partnership with the British Heart Foundation National Centre for Physical Activity and Health at Loughborough University (now SSEHS Active)
[3] The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

Measurement and Evaluation Findings – Tier 1: Learning

The measurement undertaken as part of the 'learning' tier was done through questionnaires which sought to understand social care professionals perceptions of, and confidence to, enable movement of people experiencing care. These were disseminated and completed pre and post the two learning events. Learning events ran from April to June and from September to November 2019 across key partnership areas in South Lanarkshire, North and South Ayrshire, Glasgow, Falkirk, Aberdeen, Dundee, Angus, Moray, Orkney and Shetland. Further mini learning events took place in other partnership areas that were not able to attend the official learning events. Qualitative evidence was captured through open-ended questions to understand what had been learnt and shared.

Key Findings

- 'Prioritisation of movement' improved from pre learning event 1 to pre learning event 2. The perception of promoting movement as a priority was scored higher than how often it was encouraged, implying a slight disparity between recognition of importance and practice.
- Perceptions of enabling movement showed moderate to large changes from pre to post learning events, but only small changes between learning event 1 to learning event 2. In particular, the learning events help boost social care professionals 'perceptions of their qualifications' and 'knowledge to support an older adult to move more'.
- 'Confidence to enable movement' improved from pre to post both learning events, with all changes being large. The largest changes were in statements around social care professionals 'confidence to assess an older person's readiness to move' and to 'take action against barriers that prevent movement'.
- The majority of care professionals reported being 'fairly active' at both learning events, and the proportion that reported being 'fairly active' increased by 3%.
- Social care professionals were most likely to encourage and introduce more daily movement or activities of daily living (ADL). Other learnings taken away from the learning events were developing action plans and focusing on small changes. Attitudes and awareness of other staff and the culture of the service was citied most often as a challenge to enabling movement for people experiencing care.

The number of questionnaires collected at both learning events are show below.

Learning Event	Pre	Post
Learning event one	568	508
Learning event two	367	320

Across both learning events, a total of 935 questionnaires were collected pre and 828 were collected post. Social care professionals from 9 of 11 partnership areas provided data from the learning events. South Ayrshire had the highest representation of social care professionals attending (14%), followed by Glasgow (12%) and Falkirk (11%). Social care professionals worked across six types of care, most commonly in care homes (62%), followed by care at home (16%). Attendees also worked across seven types of job roles, with the role of carer / care professional being the most frequently reported (22%). This was closely followed by wellbeing/ activity coordinators (20%) and those in manager / leadership roles (21%).

In addition to social care professionals, Allied Health Professionals and nurses attended the learning events (both 5%). This may be explained by the inclusion of a community hospital in the wider learning events, which was done with the aim of integrating some of the CAPA principles within the hospital to support the promotion of movement within the wards.

Learning event findings

All data collected from the learning events compares scores given around different statements taken pre (before) and post (after) the learning events. Score changes are compared, using statistical analysis known as linear mixed modelling, over the short term (pre to post) and the long term (learning event to learning event). Short term changes refer to changes measured across a short period of time; due to the

short time period between the measures changes cannot be referred to as long lasting. However, long term changes refer to changes measured across a longer period of time, i.e. between the two learning events. These allow us to infer whether the short term changes translate into long term change. Together these are used to understand the impact the learning events had on social care professionals' perceptions of, and confidence to, enable movement. The different statements are explored in the sections below.

Prioritisation of Movement

To determine how social care professionals prioritise movement in a care setting, attendees rated, on a scale of 0 (low) to 10 (high), their agreement with two statements.

Table 1. The pre post means [95% confidence intervals (CI)] for each learning event, with effect sizes, including for learning event 1 to 2.

	Learning Event 1			Learning Event 2			Learning event 1 to 2
Statement	Pre	Post	Effect size of difference	Pre	Post	Effect size of difference	Effect size of difference
How often do you encourage movement with those in your care?	7.79 [7.64-7.93]	8.09* [7.94-8.24]	0.292	8.16 [7.99-8.33]	8.56* [8.38-8.73]	0.387	0.407*
How much of a priority is promoting movement within your current role?	8.30 [8.16-8.44]	8.97* [8.83-9.12]	0.577	8.74 [8.57-8.90]	9.12* [8.94-9.29]	0.329	0.249*

The effect size of the difference indicates the magnitude of change (e.g. how big the change is). Less than 0.3 = trivial change, 0.3-0.5 – small change; 0.5-0.8 – moderate change; 0.8+ = large change.
Confidence intervals (CI) show the precision of this estimate and, where this data collection and analysis replicated would be expected to capture the true population estimate in 95% of replications.
*indicates statistically significant difference from pre to post / learning event 1 to 2, where $p \leq 0.001$.

On average, social care professionals scored high on both statements pre both learning events, and an increase in scores was seen from learning event 1 to pre learning event 2 (Table 1). **These improvements were statistically significant both in the short term (pre to post) and in the long term (learning event 1 to 2).**

The magnitude of these improvements varied – for 'priority of promoting movement' the scores changed by a moderate amount from pre to post learning event 1 and a trivial amount across learning events, indicating that a greater shorter term effect exists for this statement. For 'encouraging movement' the opposite was the case, whereby social care professionals rated a small change in this statement over the longer term. This implies a disparity between the recognition of importance of movement and the implementation of it in practice.

Movement in Care

To determine how social care professionals perceive movement in care and their confidence to enable movement in a care setting, attendees rated, on a scale of 0 (low) to 4 (high), their agreement with the statements below (Table 2).

Perceptions of movement

Attendees reported statistically significant improvements in all of these statements from pre to post the learning events (Table 2). They were also all statistically significant from learning event 1 to learning event 2. The magnitude of changes in certain statements were higher than others and changes from pre to post learning event 1 tended to be larger than from pre to post learning event 2. **This was particularly the case for statements around 'feeling qualified to promote movement', 'knowledge around promoting movement' and 'confidence to support an older person to move more', indicating a large short term change**. Longer term changes for all statements tended to be trivial to small, again indicating that there is a greater short term effect of the learning events.

Across both events the greatest improvements were seen in response to questions relating to the perceptions of being knowledgeable and qualified to enable movement.

Areas that saw a positive, significant change that was only trivial or small both in the short and long term included statements focused on having time within ones role to promote movement, and having a culture that supported movement. Coupled with open-ended and focus group data from social care professionals, this can be explained by the time taken for culture and attitudes in a service environment to change. These may be factors that change more in the longer term, beyond the five month gap between learning events.

Table 2. The pre post means [95% confidence intervals (CI)] for each learning event, with effect sizes, including for learning event 1 to 2.

	Learning Event 1			Learning Event 2			Learning event 1 to 2
Statement	Pre	Post	Effect size of difference	Pre	Post	Effect size of difference	Effect size of difference
I feel qualified to promote movement to older people	3.10 [3.05-3.15]	3.65* [3.60-3.71]	1.123	3.36 [3.30-3.43]	3.73* [3.66-3.80]	0.747	0.343*
I know enough about movement to encourage older people to move more	2.96 [2.92-3.01]	3.68* [3.63-3.73]	1.464	3.35 [3.29-3.41]	3.76* [3.69-3.82]	0.833	0.474*
I am confident in my ability to support an older person to move more	3.19 [3.14-3.24]	3.67* [3.62-3.72]	1.005	3.41 [3.35-3.47]	3.75* [3.69-3.81]	0.711	0.317*
I have time within my role to promote movement amongst those in my care	2.88 [2.82-2.95]	3.33* [3.26-3.39]	0.733	3.01 [2.93-3.09]	3.35* [3.26-3.43]	0.558	0.121*
I feel that the current culture within my service supports older people to be regularly active	3.06 [2.99-3.12]	3.28* [3.22-3.35]	0.410	3.13 [3.05-3.20]	3.39* [3.31-3.47]	0.471	0.158*
In general, I support those who experience care to move more on a regular basis	3.17 [3.12-3.22]	3.51* [3.46-3.57]	0.672	3.43 [3.36-3.49]	3.66* [3.59-3.73]	0.444	0.389*

The effect size of the difference indicates the magnitude of change (e.g. how big the change is). Less than 0.3 = trivial change, 0.3-0.5 – small change; 0.5-0.8 – moderate change; 0.8+ = large change.
Confidence intervals (CI) show the precision of this estimate and, where this data collection and analysis replicated would be expected to capture the true population estimate in 95% of replications
*indicates statistically significant difference from pre to post / learning event 1 to 2, where $p \leq 0.001$.

In comparison to answers given to the same questions at the first learning event (2018) in the first phase of the CAPA programme, **it is clear that the learning events across both phases of CAPA are effective in influencing perceptions of qualifications and confidence of social care professionals.**

Confidence to enable movement

On average, all scores of confidence to enable movement improved significantly from pre to post the learning events and from learning event 1 to learning event 2 (Table 3). **This suggests that taking part in the learning events boosts the confidence levels of social care professionals by providing them with further knowledge, guidance, support and ideas of how to enable movement within their care service.**

The magnitude of the change was greater at learning event 1 than learning event 2, however from pre to post at both events there were moderate or large changes to statement scores. Across both learning events, statements which saw the largest change in scores was seen in social care professionals

'confidence to assess an older person's readiness to move', to ''take action against barriers that prevent movement' and 'creating an active environment for an older person to move more'. Social care professionals were least confident in the ability 'to advise an older person on the importance of moving more', which resulted in the smallest change.

Table 3. The pre post means [95% confidence intervals (CI)] for each learning event, with effect sizes, including for learning event 1 to 2.

	Learning Event 1			Learning Event 2			Learning event 1 to 2
Statement	Pre	Post	Effect size of difference	Pre	Post	Effect size of difference	Effect size of difference
Assess an older person's readiness to move	2.87 [2.81-2.92]	3.42* [3.37-3.48]	1.123	3.05 [2.98-3.11]	3.51* [3.44-3.58]	0.939	0.270*
Advise an older person on the importance of moving more	3.22 [3.17-3.27]	3.67* [3.62-3.72]	0.993	3.46 [3.40-3.52]	3.77* [3.71-3.83]	0.682	0.371*
Identify the challenges and barriers that prevent older people from moving more	3.04 [2.99-3.09]	3.56* [3.51-3.61]	1.070	3.33 [3.26-3.39]	3.64* [3.58-3.71]	0.659	0.381*
Take action to address barriers that prevent older people from moving	2.97 [2.92-3.02]	3.54* [3.49-3.60]	1.104	3.19 [3.13-3.26]	3.62* [3.55-3.69]	0.819	0.282*
Support an older person to move more frequently	3.19 [3.14-3.23]	3.66* [3.61-3.71]	1.029	3.41 [3.35-3.47]	3.72* [3.66-3.78]	0.662	0.308*
Create an active environment for an older person to move more	3.07 [3.02-3.12]	3.61* [3.55-3.66]	1.080	3.291 [3.22-3.35]	3.70* [3.63-3.77]	0.832	0.311*

The effect size of the difference indicates the magnitude of change (e.g. how big the change is). Less than 0.3 = trivial change, 0.3-0.5 – small change; 0.5-0.8 – moderate change; 0.8+ = large change.
Confidence intervals (CI) show the precision of this estimate and, where this data collection and analysis replicated would be expected to capture the true population estimate in 95% of replications
*indicates statistically significant difference from pre to post / learning event 1 to 2, where $p \leq 0.001$.

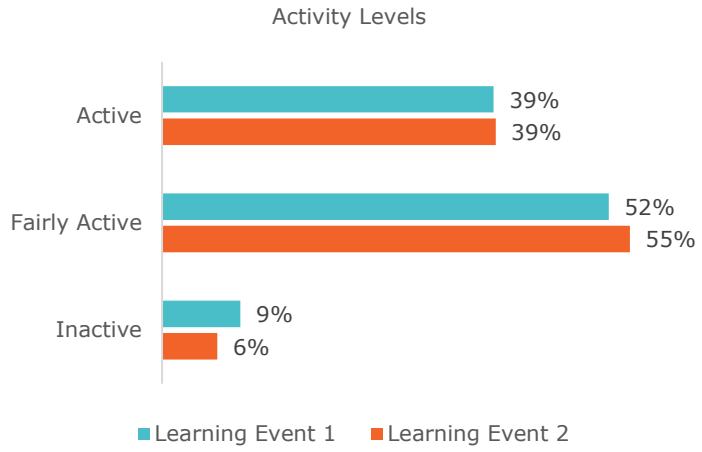
The size of change in scores from learning event 1 to learning event 2 were smaller than the changes from pre to post each learning event, but particularly learning event 1. This implies most of the learning and development in knowledge and confidence to enable movement is accumulated at the first learning event. While scores continued to improve at learning event 2, because these changes were small it implies that the learning events have the most impact the first time an individual attends. When looking at particular statements, **'identifying challenges and barriers that prevent older people from moving more' saw the greatest magnitude of change across learning events.**

Activity Levels and awareness

Care Professionals were asked whether they were aware of the Chief Medical Officer's guidelines around physical activity. Awareness increased from learning event 1 to learning event 2, as seen in Table 4, however social care professionals were most likely to report that they were unsure of the guidelines.

Table 4. Awareness of CMO guidelines

Awareness of CMO guidelines	Learning Event 1	Learning Event 2
Yes	29%	43%
No	18%	8%
Unsure	53%	49%



Although the proportion of social care professionals who reported being active remained the same from learning event 1 to learning event 2 (39%), a small proportion moved from inactive to fairly active (3%).

Nonetheless, close to two thirds are not completing the CMO guidelines of physical activity, and there remains scope to engage the 'fairly active' staff in more activity.

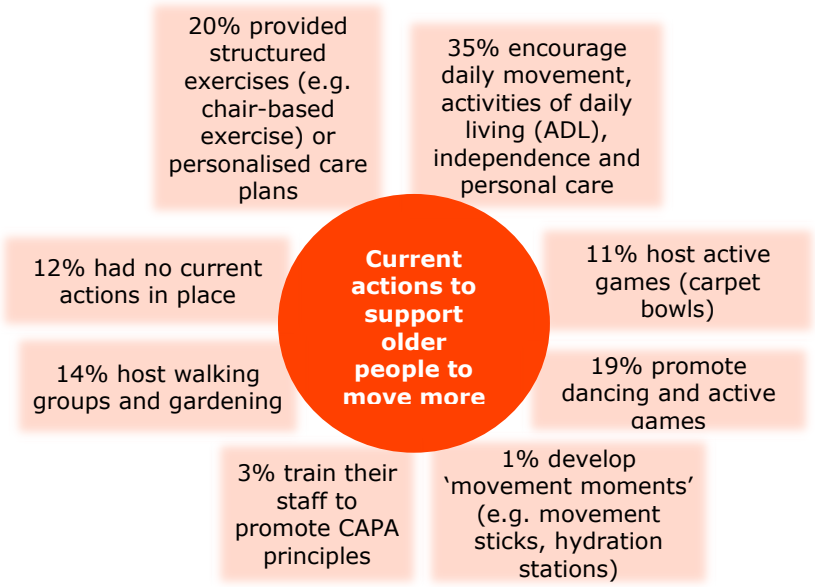
CAPA Programme Story – the role of the learning events in idea sharing

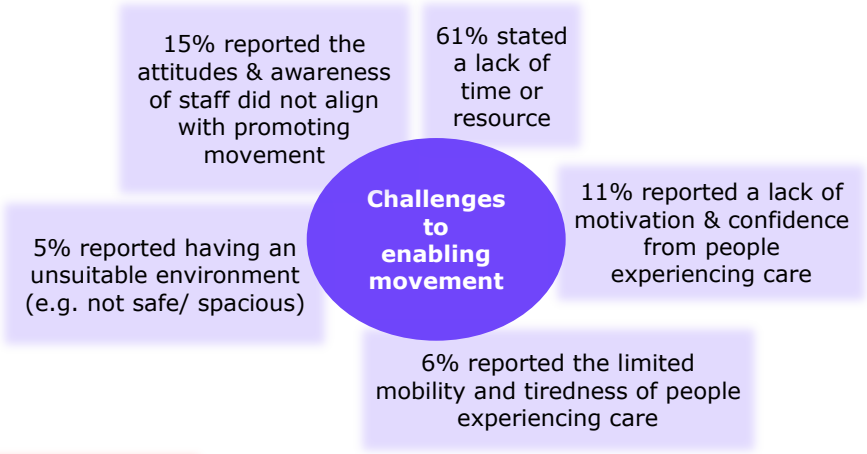
After attending the first learning event, a care at home provider began changing their paperwork to include the moving more message in their assessments, support plans and reviews. As a result of what they had learnt from the event, they altered their training approach to include ideas from the learning events about how to enable movement. They also encouraged their staff to feedback about the ideas they had and the steps they were taking.

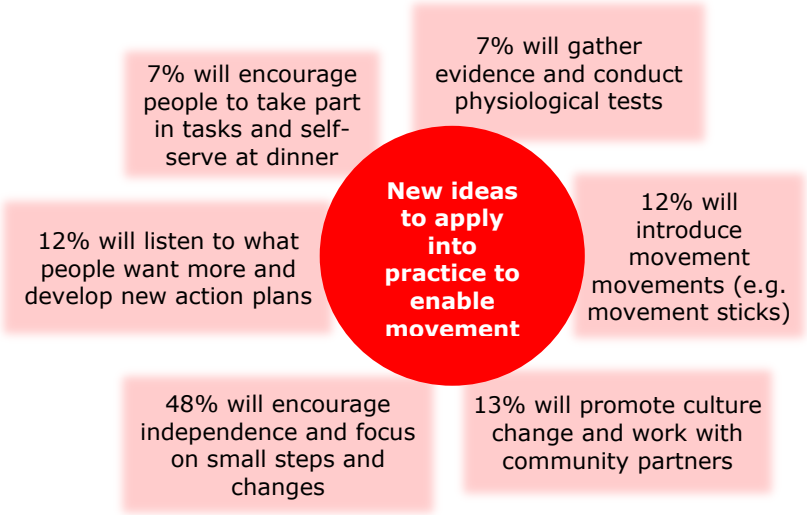
Social care professionals provided a variety of examples, including encouraging people experiencing care to complete their own personal care (e.g. bringing in their laundry and tying their own shoe laces), and making the outside space more accessible for people who wanted to go for outdoor walks. Feedback from people experiencing care was also gathered – individuals reported feeling happier by the increased social interaction they had with staff and felt more supported to be independent.

Learnings, challenges and ideas around enabling and promoting movement

Attendees of the learning events answered an open-ended question about the challenges that prevent them from enabling movement, actions they are currently doing to support older people in care to move, and new ideas they will take away and apply or translate into practice. Across the two learning events, the proportion of answers to each were calculated. This provides insight into the actions and plans, and also barriers that care services faced throughout the project.







Measurement and Evaluation Findings – Tier 2: Translation

The 'translation' tier explores how theoretical learning and sharing of best practice from the first learning event has been applied in practice, and translated into change. Qualitative evidence was captured via focus groups with social care professionals and people experiencing care to understand what had been changed and adopted. In addition, case studies and stories were captured that highlight changes in practice.

Key Findings

- People experiencing care and social care professionals described a variety of different opportunities to engage in movement. These are classed as 'unstructured movement' (e.g. every day movements and activities of daily living), 'semi-structured movement' (e.g. dancing, day trips) and 'structured exercise' (e.g. exercise classes and games).
- Social care professionals identified knowledge and practice that helped promote movement including making small cultural changes in their care environments, improving communication and support, being less risk adverse and being more adaptable.
- Areas for sustainability highlighted by social care professionals included cultural change, community partnerships, sharing best practice, and staff training.

Five focus groups were conducted on the 2nd and 3rd of July 2019 and the 3rd and 4th of December 2019 by the ukactive Research Institute. Both people experiencing care (n=27) and social care professionals (e.g. activity coordinators and carers, n=19) took part in the focus groups, from across eight care services in Glasgow, South Lanarkshire, Dundee, Tayside and Aberdeen. People experiencing care described what activities they had the opportunity to take part in and social care professionals explained in detail any changes that had occurred in practice around the care home. These responses were combined into themes and are shown collectively below. Further detail around experiences are explored on page 21.

Structured exercise	Semi-structured movement	Unstructured movement
Activities that are structured or set by care service	*Activities that are unstructured and set by a care service*	*Every day movements and 'stealth activity' (a.k.a. being active without*
› Chair & hand exercises. › Chair yoga and sports (e.g. volleyball). › Games (e.g. charades, carpet bowls, skittles). › Movement moments (e.g. using egg timers, movement sticks, and fortune cookies to prescribe exercises). › Use of pedals and Thera-bands. › Prescribed physiotherapy. › Individual exercise plans with set exercises. › CAPA data collection (e.g. sit to stand, get up and go).	› Dance. › Swimming. › Theatre. › Day trips (e.g. to the beach). › Walking groups. › Events (e.g. Aberdeen 'golden games', themed festivals). › Table tennis club. › Intergenerational visits and activities (e.g. with nursery children). › Therapets.	› Integrating movement into day to day activities that already happen (e.g. adding movement into dominos). › Encouraging individuals to help to complete ADL (e.g. laundry, sweeping, dishes). › Provide buffet lunches that encourage individuals to help themselves. › Deliver newspapers. › Gardening. › Hobbies (e.g. arts and crafts). › Baking. › Assisting others (e.g. helping pour others tea).

As part of translation into practice, social care professionals also spoke about new knowledge they had gained, how they had implemented such knowledge and plans for sustainability of CAPA.

Knowledge and understanding

Services learnt…

… about how to support those with dementia – by suggesting activities and exercises that people used to do and that provides them with routine and focus (e.g. encourage old hobbies or more ADL).

… about making small cultural changes – which are centred around what the care service and staff already do (e.g. changing meal times to encourage more movement), and align with the service identity and mission.

… to be adaptable – with taking ideas and adapting them so it fits in with the care service and peoples capabilities. For example, adapting 'chair boules' for wheelchair users by hand-making a small ramp.

… about the importance of support – to help spread the message of CAPA. Staff took a while to willingly change their behaviour and approaches, but were more likely to do this when supported by other staff.

… about developing an evidence-base – to improve buy in from staff and families. Both are more likely to support CAPA if they can see the benefits for the person experiencing care, both physically and mentally.

Implementation and practice

Services have…

… started to plan – by implementing mobility care plans social care professionals are focusing more on people's strengths and what they can do for themselves, and setting structure and plans to movement opportunities.

… become more risk enabling–– by re-evaluating risks, and understanding that certain risks are acceptable, social care professionals are beginning to support more people take them.

… gone back to the code of practice – social care professionals were reminded, through CAPA, about the Health and Social Care standards, which is to allow independence and choice of those in their care, and so have used this as a foundation for promoting movement.

… used communication – to explain the purpose of CAPA and how it will benefit people experiencing care to staff and families. This has improved social care professionals buy in and supported cultural change.

… used the power of leadership – buy in from staff and cultural change has been more successful when driven by higher level management and supported by talks and training provided by the CAPA advisors.

Sustainability

Services will…

…start small and think big – by continuing to think of the small changes that can occur around the care environment, that are feasible and realistic but have a big impact.

… maintain links with the local community - from schools to volunteers and involve them in activities hosted for people experiencing care (e.g. in care home/day care settings) and become members of community clubs (e.g. swim clubs and bowling centres) to build relationships and make connections

… continue to share best practice – through meetings across care services, especially those that share a single overarching body (e.g. Dundee CH).

…continue to utilise and build relationships - with other care services, as a result of attending the learning events.

…upskill social care professionals – by sending staff on training, supporting staff to share learning, and acting as role models to ensure they have the confidence to support people experiencing care to engage in movement.

CAPA Programme Story – social care professionals giving independence back

Following a fall, Harriet, an 84 woman living at home receiving care at home, was reported to decline in her physical ability, took few opportunities to be social and appeared to deteriorate psychological as a result. Despite this, Harriet was determined to continue living at home.

Home carers identified opportunities for Harriet to be active in order to support her independence and allow her to continue living alone. For example, they recognised that they were doing many of the small tasks that Harriet could do for herself, and they were using the visit time to complete. In handing the responsibility of these tasks back over to Harriet, staff were able to focus more time during their visits on daily exercises, building motivation and social interaction with Harriet. Staff also introduced the use of 'movement sticks', an idea shared through the CAPA learning events and social networks, which helped Harriet to participate in different simple exercises each day in an engaging and fun manner.

In addition to making visits more meaningful for Harriet, staff introduced a bedtime routine which Harriet could complete before the carers arrived; this included closing blinds, preparing her hot water bottle for bed, and setting out what was required for her supper. This gave Harriet a greater sense of purpose and integrated additional, purposeful movement into her day.

Harriet began to complete exercises outside of the staff visits, and reduced her time spent sitting by incorporating these into her daily routine. After 6 to 8 weeks purposeful movement routines Harriet was able to reduce her use of pain medication for chronic back pain. She also reported being more confident, happier and more independent in the tasks she was doing.

CAPA Programme Story – changes to the physical environment to encourage movement

A care home recognised the opportunity to encourage people experiencing care to move more by making changes to the physical environment in the service. This specifically involved increasing the distance between the lounge, where people experiencing care would sit, and the dining room by closing the adjoining door.

This was introduced one meal time, with the positive realisation that this made people experiencing care move further than originally before they sat down for meal time. In order to encourage individuals and provide them with the opportunity to complete this movement, meal time started earlier and activities and songs were introduced as part of the walk to motivate individuals.

Subsequently the door was kept closed for breakfast and dinner and now people experiencing care expect this to remain closed and automatically walk around to the dining areas if they can. It was also noted that prior to this small change a number of people experiencing care (six) required a stand aid for transfers throughout the day, however eight months after the change was implemented none of these people experiencing care required aids to stand up.

Measurement and Evaluation Findings – Tier 3: Impact

The 'impact' tier explores the impact that the learning and translations have had on people experiencing care. This includes data captured from: 1) physiological tests (taken every six-weeks); 2) psychological variables (asked through questionnaire every six-weeks) and 3) focus groups with people experiencing care, and improvement stories provided by social care professionals. Data collected at each time-point from baseline (the first time a measurement was taken), every six-weeks up to 36-weeks (the last data collection time point). Initial baseline data collection could have been taken at any point during the CAPA delivery (a flexible baseline), dependant on the action plan of individual service which impacted the number of data points collected for each individual.

All data collected across all time points is reported, even those with smaller sample sizes, to transparently represent the data collected. Towards the end of the delivery, lower sample sizes are seen, which should be considered when comparing changes to larger sample sizes at the beginning of the programme. However, the drop off in sample sizes is not unusual for a programme of this kind and are not necessarily a reason for concern as they provide important learnings around the feasibility of data collection in a real-world setting. Social care professionals primarily captured data, focusing on collecting as much data as possible, but aiming to collect four data time point measurements for each individual, so as to fit data collection into their full time roles. This will in part explain the loss in follow up over time, in addition to other factors such as people experiencing care moving between or out of care settings or experiencing illness. The latter examples, however, do not mean individuals 'dropped out' of the intervention and did not experience benefits from partaking, but instead that data was not captured from them at these later time points.

All data time points have been included in statistical analysis. Where results are statistically significant, it means that, if we assumed that the intervention had no effect, observing a change at least this large would be unlikely due to chance – and thus we infer it is likely a true change.

Key Findings

- There was a significant decrease in the FROP-COM (Falls Risk for Older People in the Community) score of people experiencing care taking part in the CAPA programme over time.
- At baseline a majority of people experiencing care spent their time sitting. Moving time gradually increased over time; at baseline 4 hours and 19 minutes per day was spent moving, which increased to 5 hours 2 minutes at 6-weeks and 12-weeks, and reduced to 4 hours 34 minutes at 18-weeks.
- Doing activities that mattered to people experiencing care significantly improved across the delivery of CAPA, as did their sense of belonging to their community and feelings of loneliness. People report that moving more often has ongoing social and psychological benefits.
- People experiencing care showed improvements in their health-related quality of life (HRQoL) over the programme ($p = 0.003$). The proportion of those who had severe problems or were unable to be mobile and complete usual activities of daily living decreased across the programmes.

Physiological impact on people experiencing care

All physiological measures were selected for their appropriateness to test body strength, movement capability, and balance in older people. Data included in analysis for this report was received by 31st of January 2020. Where available, comparisons are made to national data to provide context to the scores. Data was received from across nine partnership areas, with the most received from South Lanarkshire (24%), North Ayrshire (14%) and South Ayrshire, Dundee City and Angus (all at 13%). Three quarters of people experiencing care (78%) whose data was received were aged between 76 and 96 years.

FROP-COM & Falls

The FROP-COM (Fall Risk for Older People in the Community) screen was used to evaluate fall risk in older adults. **There was a significant decrease in the FROP-COM score of people experiencing care taking part in the CAPA programme completed over time ($p<0.001$).** Significant reductions were seen from the initial data collection time point to each of 6-weeks, 12-weeks, 18-weeks, and 24-

weeks. As there were no other significant interactions between other time points it can be suggested the greatest impact was seen within the first 6-weeks which was then maintained. The mean FROP-COM scores indicate that on average fall risk was considered low, even at baseline.

Table 5. FROP-COM mean scores from across the CAPA programme

	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks	36-weeks
N	252	161	112	76	48	20	14
Mean (95% CI)	3.38 (3.12-3.64)	2.68 (2.38-2.98)	2.83 (2.49-3.16)	2.94 (2.56-3.31)	2.88 (2.43-3.32)	2.85 (2.22-3.48)	2.89 (2.15-3.64)

A score of 0-3 = low fall risk, a score of 4-9 = high fall risk.

The total number of people experiencing care falling and their total number of falls reduced across the data collected from CAPA. The rate of falling and falls also reduced over time, with the exception of an increase at 18-weeks. It is unclear why there was an increase at this time point. At baseline 60 people were reported to have fallen within the previous six-weeks with a total of 129 falls. This was at a rate of 6.4 people falling and 13.8 falls per 1,000 people days. At 30-weeks this reduced to four people falling within the previous six-weeks with a total of four falls, at a rate of 4.0 people falling and 4.0 falls per 1,000 people days.

Table 6. The total number and rate of people falling across the CAPA delivery

	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks
Number of people falling	60	23	22	15	7	4
Falling rate*	6.4	3.3	4.5	4.5	3.7	4.0
Total number of falls	129	38	42	44	13	4
Falls rate *	13.8	5.5	8.6	13.3	6.9	4.0

*rate is calculated based on the event happening per 1,000 people days. For example, the rate would be the same if you observed x number of falls in 1,000 individuals observed for 1 day, or similarly if you observed x number of falls in 1 person for 1,000 days. The rate is therefore calculated based on the number of people falling (not considering the number of falls) or total number of falls per 1,000 people days.

Similar to the falls data, **the total number of people experiencing care who had medical service contacts as a result of their falls and their total number of medical service contacts reduced across the data collected from CAPA.** The medical services contact rate reduced at six-weeks before increasing at 12-weeks and 18-weeks, reducing again at 24-weeks, with a final increase at 30-weeks. This suggests that fewer medical contacts were made across all people experiencing care and implies that participation in the CAPA programme can help provide additional support for reducing falls experienced.

At baseline 20 people were reported to have had contact with medical services as a result of falls within the previous six-weeks with a total of 31 visits. This was at a rate of 2.1 people contact rate and 3.3 contacts per 1,000 people days.

Table 7. The total number and rate of medical service contacts as a result of falls across people experiencing care over CAPA delivery

	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks
Number of contacts with medical services as a result of falls	20	9	10	6	2	1
Medical services people contact rate*	2.1	1.3	2.1	1.8	1.1	1.0
Total number of medical services contacts	31	11	10	9	3	2

Medical services contact rate*	3.3	1.6	2.1	2.7	1.6	2.0

*rate is calculated based on the event happening per 1,000 people days. For example, the rate would be the same if you observed x number of medical services contacts in 1,000 individuals observed for 1 day, or similarly if you observed x number of medical services contacts in 1 person for 1,000 days. The rate is therefore calculated based on the number of people having medical services contacts (not considering the number of medical services contacts) or total number of medical services contacts per 1,000 people days.

Hand Grip Strength

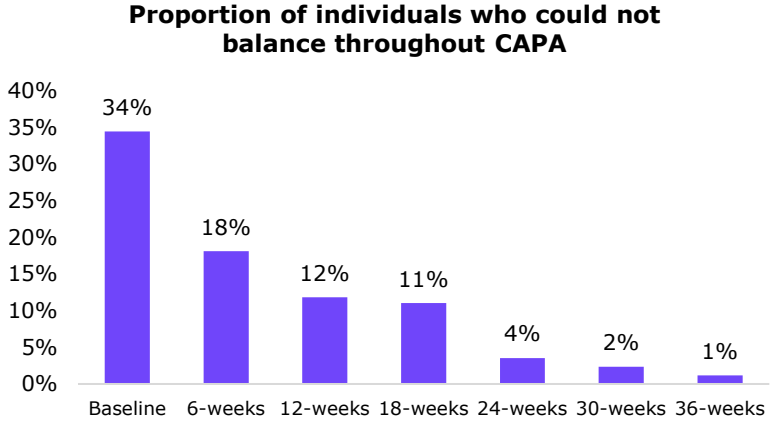
Hand grip strength was measured using a hand grip dynamometer, with measurements taken from each hand. The total number of responses at each time-point can be seen in the table below. **There was no significant change in hand grip strength over time.** For the interaction of initial data collection, 6-weeks, and 12-weeks with 18-week data, there were significant reductions in strength however it is unclear on why there was a reduction in strength at this time only.

Table 8. The total number of and means of Hand Grip Strength responses

	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks	36-weeks
N	254	183	133	83	42	20	9
Mean (95% CI)	13.7 (12.6-14.9)	13.6 (12.4-14.8)	13.6 (12.2-14.9)	11.8 (10.2-13.4)	13.5 (11.4-15.6)	12.5 (9.6-15.3)	12.4 (8.3-16.5)

Standing Balance

Standing Balance was used to evaluate balance ability in older adults. **There was a significant increase in the length of time people experiencing care taking part in the CAPA programme were able to stand on one leg for data completed over time (p=0.017).** Significant improvement interactions between baseline, 6-weeks, 12-weeks, and 18-weeks with the data collected at 24-weeks. This suggests that the people experiencing care continued to improve through to 24-weeks, even though there was a lower mean standing balance score at 18-weeks.



When looking at scorings individually, the proportion of people experiencing care who were not able to balance (score of 0 seconds) decreased across the CAPA programme. This may be because being more able to stand independently due to improved strength. This also indicates that individuals are capable of improving their balance scores.

Table 9. The total number of and means of Standing Balance responses

	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks	36-weeks
n	218	161	109	69	37	19	10
Mean (95% CI)	9.4 (6.7-12.1)	12.5 (9.4-15.5)	12.1 (8.5-15.6)	9.5 (5.2-13.8)	19.4 (13.8-25.1)	10.6 (2.8-18.3)	6.2 (-4.3-16.6)

Sit to Stand

Sit to stands are the number of complete stands a person can make from a seated position in 30 seconds. This test measures leg strength and endurance. Due to the population, a modified sit to stand test was used whereby people experiencing care were able to use their arms to aid the test. The majority of participants did use their arms.

There was a significant increase in the number of sit to stands people experiencing care taking part in the CAPA programme completed over time (p=0.022). Significant improvements were seen from initial data collection to each of 6-weeks, 12-weeks, 24-weeks, and 36-weeks. As there were no other significant interactions between other time points it can be suggested the greatest impact was seen within the first 6-weeks which was then maintained. This may be explained by the opportunities for people experiencing care to be more mobile, as overall leg endurance is improved by engaging in regular movement.

Table 10. The total number of and means of Sit to Stands responses

	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks	36-weeks
n	245	164	110	37	55	19	9
Mean (95% CI)	5.9 (5.2-6.5)	6.8 (6.1-7.5)	7.0 (6.2-7.8)	6.2 (5.0-7.5)	6.9 (5.8-7.9)	7.0 (5.4-8.7)	8.2 (5.9-10.4)

Timed Get Up and Go

The Timed Get Up and Go was used to evaluate a person's ability to stand up from a seated position and walk 3 meters, either with or without a walking aid turn around, and walk back and sit back down. **There was no significant change for people experiencing care taking part in CAPA in the timed up and go.** However, there was a significant increase in the timed get up and go between baseline and 6-weeks

Normative data[4] indicates that a score of 10 seconds or less is normal, and a score of 30 or less indicates that the individual requires aid to walk, or has problems walking, but is still able to do so. Compared to the breakdown of scores from people experiencing care, the mean values all indicate that people experiencing care require support when walking. However, the lower confidence intervals indicate that there are participants who score less than 10 seconds. It should be considered that **a score of over 14 seconds has been shown to indicate high risk of falls. Given the average scores at each time point, there is a good opportunity to promote continued movement** to improve gait and the timed get up and go scores and has the potential to decrease the risk of falls.

Table 11. The total number of and means of Timed Get Up and Go responses

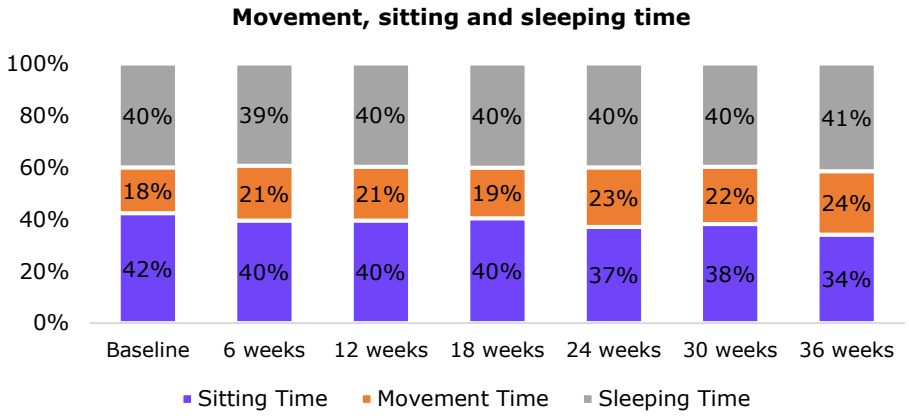
	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks	36-weeks
n	210	144	100	54	32	13	5
Mean (95% CI)	46.4 (38.8-53.9)	57.0 (48.4-65.5)	49.4 (39.6-59.1)	50.4 (38.2-62.6)	46.8 (31.6-61.9)	53.9 (31.3-76.5)	71.4 (36.3-106.5)

Movement Impact on People Experiencing Care

Individuals were asked to estimate how many hours per day, on an average day, they spent sitting, moving, and sleeping. Movement included movement both in and out of a seated position.

On average, people experiencing care are **spending the majority of their time either sitting or sleeping.** Approximately a fifth of their time is spent moving.

[4] https://www.thompsonhealth.com/Portals/0/_RehabilitationServices/PT%20Mgmt%20of%20Knee/Functional_Tests.pdf



Of the time spend moving, this equates to an average of 4 hours and 19 minutes per day at the initial data collection, increasing to 5 hours 2 minutes at 6-weeks and 12-weeks, before reducing to 4 hours 34 minutes at 18-weeks.

Psychological impact on people experiencing care

People experiencing care answered questionnaires which measured their mental wellbeing, sense of purpose, loneliness, health related quality of life (HRQoL) from which it is possible to calculate quality adjusted life years (QALYs), and self-reported sedentary and movement levels. Data included in analysis was received by 30th January 2020.

Sense of Purpose

Table 12. The proportion of individuals giving each response around their sense of purpose across the CAPA programme

I am doing more of what matters to me...	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks	36-weeks
All the time / Often	38%	49%	44%	47%	49%	58%	57%
Sometimes	40%	31%	40%	46%	24%	29%	36%
Not much / not at all	22%	20%	16%	7%	26%	13%	7%

People experiencing care taking part in the CAPA programme reported more positively that what they are doing what matters to them. This was highest at 30-weeks, were 58% of people experiencing care who responded said they were doing activities that mattered to them all the time or often. 6-weeks. Most felt they were doing activities that mattered to them sometimes/often. **Doing activities that mattered to people experiencing care significantly improved across the delivery of CAPA ($p<0.001$).** There were significant interactions from baseline with all of the follow up time points, suggesting the initial increase was sustained throughout the CAPA delivery. There were also significant interactions from 6-week and 12-week.

Social belonging and Loneliness

Table 13. The proportion of individuals for each response for belonging to their community across the CAPA programme

I feel like I belong to my community…	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks	36-weeks
Very / fairly	64%	63%	64%	71%	78%	63%	57%
Somewhat	20%	26%	32%	21%	17%	33%	36%
Not very / not at all	16%	11%	5%	8%	4%	4%	7%

When asked about belonging to their community and if they ever felt lonely people experiencing care responded positively. The majority of people experiencing care felt 'fairly' or 'very' strongly about their belonging to the community at all time points, which remained consistent**. There was a significant improvement in perceptions of feeling part of ones community over time for people experiencing care taking part in CAPA (p=0.029).** Significant improvements occurred between baseline and data collected at 24-weeks, 30-weeks, and 36-weeks, as well as both 12-week and 18-week with 36-week data. Similarly, the majority of people experiencing care only rarely or some of the time felt lonely, which was best at 12-weeks**. There was a significant improvement in loneliness scores over time for people experiencing care taking part in CAPA (p<0.001).** The interaction between time points revealed significant interactions for loneliness between both baseline and 12-weeks with data collected at 18-weeks, 24-weeks and 30-weeks.

Table 14. The proportion of individuals for each response for feeling lonely across the CAPA programme

During the past week, I have felt lonely…	Baseline	6-weeks	12-weeks	18-weeks	24-weeks	30-weeks	36-weeks
Rarely (e.g. less than 1 day)	43%	45%	51%	49%	54%	25%	43%
Some of the time (e.g. 1-2 days)	32%	30%	31%	37%	33%	42%	29%
Occasionally (e.g. 3-4 days)	20%	19%	16%	12%	11%	25%	21%
All of the time (e.g. 5-7 days(	5%	6%	2%	3%	2%	8%	7%

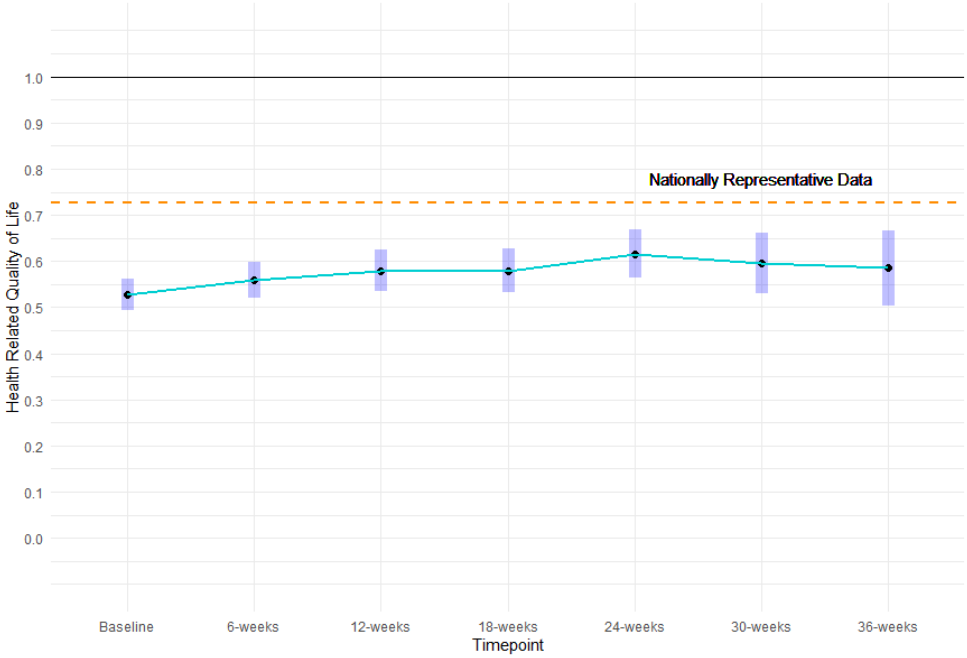
Quality adjusted life years (QALYs) and Health-related Quality of Life (HRQoL)

HRQoL was determined through the EQ-5D questionnaire. This involves five questions assessing an individual's self-rated mobility, self-care, engagement in usual activities, and reported pain, anxiety or depression, and an additional self-rated perceived health question. Collectively this can be used to determine HRQoL which runs on a scale from 0 (dead) to 1 (perfectly healthy). The HRQoL experienced over time can also be utilised to calculate QALYs indicating the life years experienced if adjusted for quality of life during that period.

Calculation of the QALYs over the data collection time points (a total period of 0.62 years) was 0.47 years. Over this period of time if a person was in perfect health they would have experienced 0.62 quality of life years. As such the QALYs score indicates that these people experiencing care were not experiencing perfect health, but given the current population, the QALYs found here is not unusual.

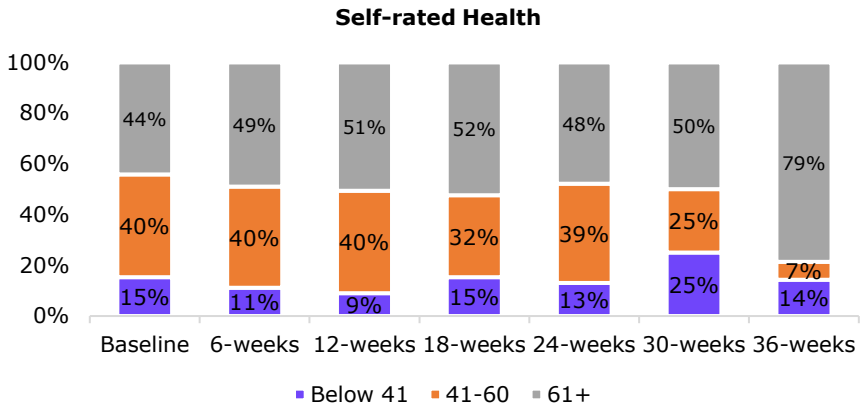
There was a small, significant improvement in HRQoL over time (p = 0.003), indicating that people experiencing care's HRQoL improved across the CAPA programme. While individuals HRQoL improved, on average it scores were significantly lower at all time points ($p < 0.005$) than nationally representative data (mean HRQoL=0.728; indicated by the dashed orange line). **However, the average changes in HRQoL were fairly similar to those seen in similar care home resident populations**

undergoing interactive exercise and physical activity classes[5]. The figure below visualises the change over time in average HRQoL as well as individual scores.



Self-related Health

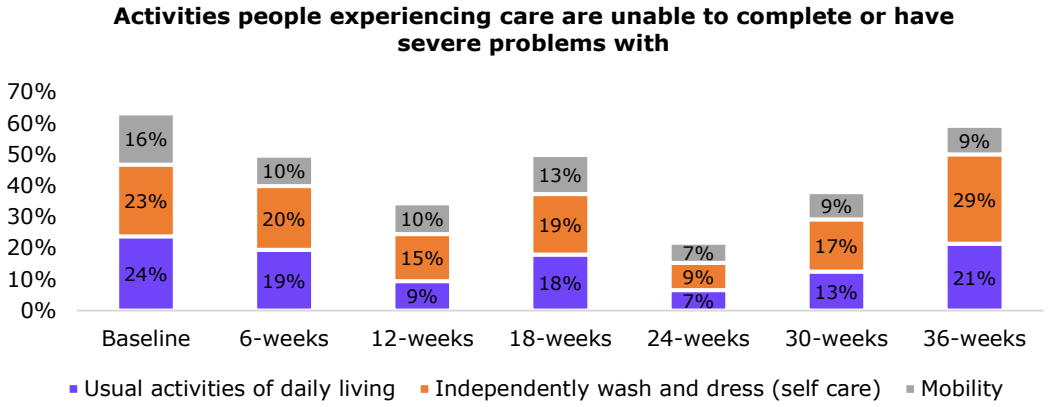
When people experiencing care rated their health today (where 0 = worst health possibly imagined and 100 = best health possibility imagined), **the proportion of people experiencing care who rated their health above 61 increased steadily over the course of CAPA**, with a slight drop at 24-weeks and 30-weeks. A similar pattern was seen for those reporting scores below 41.



Activities of Daily Living (ADL) and Independent self-care

Out of the six questions, a snap shot is provided into mobility, ability to complete activities of daily living (ADL) and to take part in independent self care.

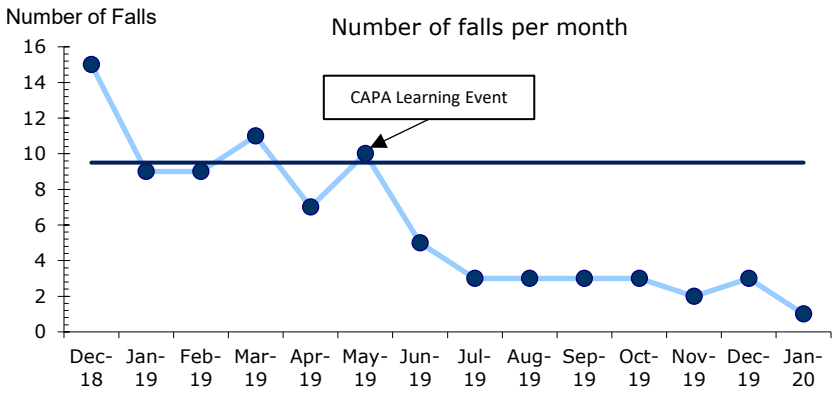
[5] Verhoef, T.I., Doshi, P., Lehner, D. *et al.* Cost-effectiveness of a physical exercise programme for residents of care homes: a pilot study. *BMC Geriatr* 16, 83 (2016). https://doi.org/10.1186/s12877-016-0261-y



The graph displays the **proportion of responses of people unable to complete or have severe problems with ADL, self-care and mobility. As can be seen this fluctuates across the course of CAPA delivery**. The proportion of people experiencing care reporting being unable to having severe problems in these areas decreased steadily from baseline to 6-weeks to 12-weeks. This increased again for all aspects at 18-weeks, decreased again at 24-weeks, to the lowest proportions yet, but increased again.

CAPA Programme Story – A whole home approach to reducing falls

All care homes monitor and collect data on the number of falls in their service. A care home noted a significant reduction in falls since being involved in the CAPA Programme. Over the 12 months they have seen a gradual decrease in the number of falls, with a noticeable drop after staff attended the CAPA learning event May 2019. In May 2019 the number of falls across the care home was ten, and as of January 2020 this had dropped to one. When comparing January 2020 to December 2018, number of falls had reduced by 15 per month.

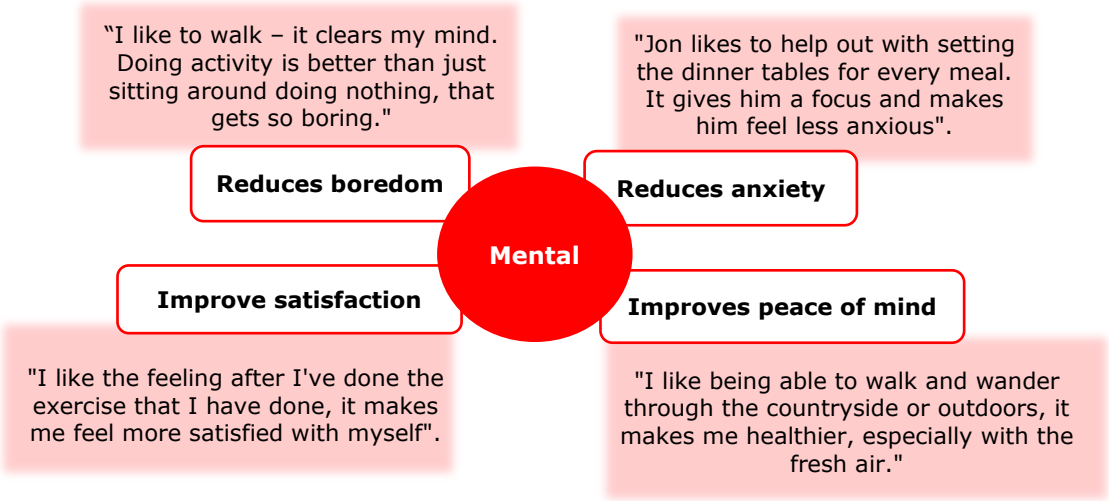


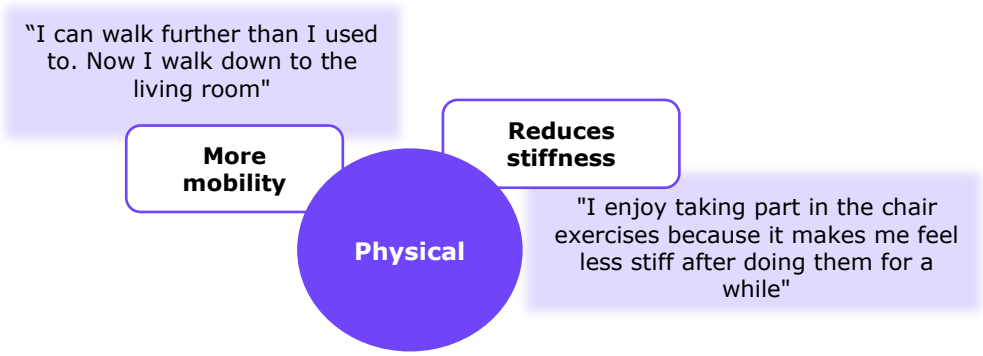
Staff and the care home manager attribute the reduction in falls to a combination of small changes that occurred over time and have contributed to a culture shift within the care home. Firstly, attending the CAPA learning event provided staff with the knowledge they needed to alter their approach and an understanding of the benefit of monitoring and collecting data over time; causing them to integrate this into their daily routines. Below are some of the key steps that the care home took, as a collective, to increase movement opportunities for people experiencing care:

- Involving all staff teams in the 'new' processes to increase movement, and holding open discussions around the role of movement, risks, and benefits in staff inductions, team meetings and supervisory meetings.
- Working across all staff to assess the abilities of people experiencing care and develop ideas that everyone could implement to support movement.
- Listening to the voices and choices of people and developing ideas based on these.
- Integrating physical activity and movement goals into care plans.
- Sharing and celebrating successes and using learnings to make changes when things did not work.
- Aligning activities offered in the care home to the health and social care standards.

Mental Health/Wellbeing

Focus groups took place with people experiencing care on the 2nd and 3rd July 2019, and the 3rd and 4th December 2019. A total of 27 individuals contributed to the focus groups. These were analysed using thematic analysis, to understand how taking part in CAPA impacted their wider wellbeing. This has been divided into impacts on mental wellbeing, physical wellbeing and individual development, and is shown below (any names used are pseudonyms).





Conclusions and Recommendations

The three tiers of the CAPA programme evaluation (learning, translation and impact) were used to demonstrate if the theoretical learnings from the learning events had a translatable and tangible impact on the movement levels of people experiencing care. This impact was measured through physiological tests, mental wellbeing assessments, and was supported by focus groups and case studies. Key findings from this phase of the CAPA project are presented below.

Conclusions

The CAPA programme model was able to fulfil its aim of making changes to the movement, wellbeing, independence and quality of life of people experiencing care. Specifically, the learning events played a successful role in supporting social care professionals to develop new skills, knowledge and confidence around enabling movement in care and share best practice. They acted on opportunities to cascade best practice, allowing new ideas and working practices to be filtered throughout care services, subsequently increasing the opportunities for movement for people experiencing care through these services. **The measurement and evaluation framework put in place was successful at capturing data to evidence changes in people experiencing care's movement, wellbeing, independence and quality of life by utilising a triangulation approach which adopted both quantitative and qualitative methodologies.** Incorporation of the qualitative methodologies also allowed additional information around changes to care services culture and routine practices to be captured.

Key findings gathered through the project are shown below.

- There were significant improvements in FROP-COM scores across the CAPA delivery, indicating a reduced risk of falls across the CAPA delivery. Alongside this, the rate of falls and overall falls rate per individual reduced.

- People experiencing care and social care professionals described a variety of different opportunities to engage in movement. These are classed as 'structured exercise' (e.g. exercise classes), 'semi-structured movement' (e.g. dance, theatre) and 'unstructured movement' (e.g. activities of daily living, personal care). Of the types of activities and movement that social care professionals reported encouraging or putting in place, activities of daily living (ADL), daily unstructured movement, and personal care were the most frequently cited. These were perceived as the most successful way to enable movement and links into making small changes to service and individual behaviour.

- People experiencing care spent a majority of their day (classed as a 24 hour period) sitting or asleep, with moving time increasing from 4 hours 19 minutes at baseline to 5 hours 2 minutes at 6-weeks and 12-weeks, before reducing to 4 hours 34 minutes at 18-weeks.

- Whilst hand grip strength remained constant, there were significant improvements in sit to stand and standing balance.

- Most of the people experiencing care taking part in the CAPA programme felt that they were doing activities that mattered to them, which significantly improved. There were also significant improvements in feeling part of one's community and a reduction in loneliness.

- There was a significant improvement in HRQoL over time, though this was small and on average people experiencing care had significantly lower HRQoL scores at all time points compared to nationally representative data.

- People experiencing care tended to engage in opportunities to move because of the wider social and psychological impacts that moving and physical activity had. For example people experiencing care felt more independent, less anxious, and less lonely because of being able to be mobile and spend time with other individuals. Additionally, people experiencing care were more likely to continue to move if they were engaging in meaningful movement, and doing activities that fulfilled their interests (e.g. hobbies).

- Social care professionals found the learning events informative, in particular in sharing best practice and taking away new ideas which they could use and adapt in their individual services. They also spoke about how social networks has been developed between services to support ongoing learning and development.

- The learning events supported social care professionals' confidence to enable movement for people experiencing care, particularly through improving their knowledge of the benefits of movement for older adults, to assess older adults' readiness to move, and to take action against barriers that prevent movement.

- Cultural change, attitudes and awareness of the importance of movement on the part of other social care professionals was cited as a frequent barrier throughout both phases of the project, which also encompassed a lack of staff training and perceptions of a lack of time and resources. However, in the second phase of CAPA social care professionals reported more ideas around how to overcome these challenges, such as making small changes into the routines that social care professionals already do.

- Data captured throughout the CAPA programme indicates that individuals have engaged with the CAPA programme across a variety of care services and other locations, including community hospitals. Changes have been made to the culture of services in order to incorporate movement into the service structure.

Recommendations

As the CAPA programme comes to a close, a variety of recommendations are given to ensure the positive outcomes seen are sustained beyond the programme end.

- As the programme comes to a close, the responsibility of the sustaining the CAPA programme is passed back to the services and partnership areas. It is recommended that services continue to engage in sharing best practice and support each other through networks, and put aside time to regularly meet and discuss challenges, barriers and solutions to overcome these.

- For any further learning and development opportunities or training put in place for social care professionals it is recommended that such training adopt similar approaches to those of the CAPA learning event, with a focus on improving their knowledge around movement and their skills and confidence to enable and promote it.

- Opportunities for people experiencing care to walk regularly, enhance balance, and enhance strength and increasing opportunities to stand up often during the day, should continue to provide individuals the opportunity to build strength and mobility. Continuing opportunities to move may also help mitigate the risk of falls through improving strength and balance, and also help to support overall health and wellbeing wider than what is measured here.

- Wider social opportunities often also promoted movement. It is thus recommended that any activities put in place to support continued activity be centred on social interaction and based upon the wants and needs of the individuals.

- It is recommended that health services involved with CAPA share their learnings with local hospital wards to support the hospital staff to enable movement within their wards.

- It is recommended that a similar model be rolled out across other home nations to support care services in England, Wales and Northern Ireland to incorporate movement into the daily lives of people experiencing care.