Physical Activity Needs Assessment

(Short version)

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Physical Activity Needs Assessment Overview: What the evidence tells us

The burden of an inactive population

Physical Inactivity is one of the top 10 causes of disease and disability in England and is attributed to 6% of deaths globally.

Inactivity is the principal cause for 21-25% of breast and colon cancer, 27% of diabetes burden and 30% of ischaemic heart disease.

It is estimated that 1,368 years of poor health are being lived by the Suffolk population each year as a direct result of physical inactivity.

Inactivity costs an estimated £7.4 billion a year to the UK.

Inactivity

Children
- In England; 36% of boys and 45% of girls were in the ‘low activity group’ (less than 30 minutes of MVPA everyday); there is a lack of current, accurate data regarding PA levels in children in Suffolk.
- Inactivity increases throughout childhood; the decline in PA starts as early as 7yrs.

Adults
- 22.7% of Suffolk adults are “inactive” taking part in less than 30 minutes of PA each week; this equates to approximately 137,000 residents.
- Many adults spend a significant proportion of their time at work seated.

Older Adults
- PA typically declines with age; in England by 75 years of age only one in ten men and one in twenty women meet the recommended requirements for good health with respect to PA.

The Chief Medical Officer’s Guidelines for PA

Children (5-18yrs)
- Should take part in at least 60 minutes of moderate to vigorous PA every day
- Include muscle and bone strengthening activities three times per week

Adults and Older Adults
- Should do at least 150 minutes (moderate intensity) or 75 minutes (vigorous intensity) or a combination of moderate and vigorous PA per week
- Include strength and balance activities two days per week
- Older adults at risk of falls should also incorporate balance and co-ordination PA at least two days per week

All the CMO guidelines for PA recommend minimising sedentary behaviour.

The proportion of adults identified as “active” taking part in more than 150 mins PA each week

Health and Wellbeing

Suffolk’s prevalence rate for (Coronary Heart Disease) CHD is 3.7%; populations who regularly partake in PA have a 20-30% lower risk of CHD.

Healthcare professionals do not always have the necessary knowledge, confidence or time to be able to support their patients to be more physically active.

Community and environment

There is a clear disparity in PA participation levels between those with a limiting illness or disability and those without.

18.6% of Suffolk residents utilise the natural assets available for exercise/health reasons. There are significant benefits to both an individual’s mental and physical well-being due to taking part in “green exercsie.”

Active Travel

The proportion of children walking regularly to school in Suffolk decreases from 49% in primary to 30% in secondary school.

61.7% of Suffolk residents walk regularly (at least 3x/wk)
8% of Suffolk primary school children and 2% of secondary school children cycle to school.
5% of Suffolk residents cycle regularly (at least 3x/wk)
Overview

This report seeks to provide an understanding of the level of physical activity (PA) participation and inactivity by children, young people and adults living in Suffolk. It also considers the impact of insufficient activity in the population across a wide range of factors including, health and wellbeing, transport, education, and the community.

The physical activity needs assessment has combined input from multiple sources including national and local policy and strategy; the scientific evidence-base; national and local data sources; epidemiological data and information gathered from insight provided by local residents and the workforce in Suffolk.

In 2014, Public Health England (PHE) issued guidance and recommendations in the ‘Everybody active, Every day’ strategy to promote and support PA in the population, with four priority areas identified as i) active society; ii) moving professionals; iii) moving at scale and iv) active environments (Varney, Brannan, & Aaltonen, 2014). This was followed by the government strategy ‘Sporting Future: A New Strategy for an Active Nation’ with a vision to increase sports and PA participation (“Sporting Future: A New Strategy for an Active Nation SportingFuture,” 2015) and the Sport England strategy ‘Towards an Active Nation’ (Sport England, 2016b) which identifies the importance of tackling inactivity and promoting behaviour change across all generations.

To stay healthy the Chief Medical Officer’s (CMO) guidelines recommend that children (aged 5-18yrs) should take part in at least 60 minutes of moderate to vigorous PA every day and include muscle and bone strengthening activities three times per week (UK Chief Medical Officer, 2011). It is recommended that adults and older adults participate in 150 minutes (moderate intensity) or 75 minutes (vigorous intensity) or a combination of moderate and vigorous physical activity (MVPA) per week, including strength and balance activities at least two days per week (Chief Medical Officer, 2011a). In addition, older adults at risk of falls should also incorporate balance and co-ordination PA at least two days per week. A key feature of all the guidelines for PA recommend minimising sedentary behaviour. (Department of Health, 2011a).

Over the last 50 years, the UK has experienced a 20% decline in PA levels (UK Active, 2014). Nationally, it is estimated that one in five children are not meeting the recommended guidelines for PA and over one in four women and one in five men do less than 30 minutes of PA a week and are therefore classified as ‘inactive’. Physical activity has essentially been engineered out of society.

There is limited available data for children and young peoples’ physical activity and sports participation levels both nationally and locally. This is as a result of a number of different factors, including: the complexity and accuracy of reporting methods in this age group; limited information available from national data sources, and limited uptake of local questionnaires and surveys. However, it is evident that the majority of children and young people in England, 23% of boys and 20% of girls aged 5-15 yrs, are not meeting the CMO recommendations for PA. (“Health Survey for
England 2015 Physical activity in children Health Survey for England 2015: Physical activity in children,” (2016). PA declines with age in young people; this is clearly shown during the transition between primary and secondary school, where over 80% of children in Suffolk’s primary schools reported being active during their free time in school time, compared to over 60% of secondary school children reported being inactive during break times in school (“The Suffolk Children’s Physical Activity Survey (11-18 years),” 2017). More recent evidence indicates that the onset in decline in PA is happening at a younger age, even as early as 7 years (Farooq et al., 2016). Sedentary behaviour during leisure time is influenced by multiple factors in this cohort including screen time and homework.

The government’s ‘Childhood Obesity Plan for Action’ identifies that tackling physical inactivity in children will be a significant contributory factor in tackling childhood obesity (HM Government, 2016). Physical inactivity has been shown to be increased in children with excess weight; 39% of healthy weight versus 45% of obese children could be classed as having ‘low activity’ ((less than 30 minutes of MVPA everyday) (“Health Survey for England 2015 Physical activity in children Health Survey for England 2015: Physical activity in children,” 2016).

In adults, increasing levels of physical inactivity are reflected through a variety of measures including: national data that show 33% of men and 45% of women are not active enough for good health; walking and cycling statistics that show walking trips decreased by 30% between 1995 and 2013 and increasing sedentary behaviour with more than 40% of women and 35% of men spending more than six hours a day desk-bound or sitting still (Varney, Brannan, & Chapman, 2017).

Recent trend data has demonstrated that between 2012 and 2015 Suffolk showed an improving picture for the proportion adults, who were physical active (56.0% vs. 57.2%). However, it is important to remember that surveys rely on self-reporting and can be influenced by over-reporting and misunderstanding of categorisation of intensity of PA (Haskell, 2012; Helmerhorst et al., 2012). There is a lack of knowledge and understanding of the CMO guidelines for PA in adults, only 20% of those surveyed locally could correctly identify the CMO guidelines for PA in adults (The Adult Physical Activity Survey for Suffolk, 2017).

PA typically declines with age, by 75 years of age only one in ten men and one in twenty women meet the recommended requirements for good health with respect to PA (Varney et al., 2014). As physical activity has been shown to prevent falls, decrease dementia rates, and diminish the consequences of other long term conditions (Department of Health, 2011b), it is imperative that individuals remain active even in older age. In particular in the older age group, respondents to the local survey identified that they preferred to be active outdoors; this included using public roads for activities such as walking and cycling (57%) and outdoor rural areas (41%) (The Adult Physical Activity Survey for Suffolk, 2017).

Certain population groups are less likely to take part in physical activity for a variety of different reasons and therefore may not be as likely to meet the current recommendations for PA. Women are less active than men across the board. In Suffolk, the proportion of men and women classified as
Physically active was 62.7% and 51.7% respectively (Sport England, 2016c). There is also a clear disparity in PA participation between those with a limiting illness or disability and those without. 35.1% of Suffolk residents with a limiting illness or disability achieve recommendations compared to 61.5% of those without (Sport England, 2016c).

PA participation is less common in more socio-economically deprived communities. The Active People Survey examined data according to the National Statistics Socio-economic classification (NS-SEC); in Suffolk, 23.4% of those grouped in the top 4 classes were classed as inactive whereas 31.7% of those in the latter 4 classes were identified as inactive (Sport England, 2016c). Activity can also be linked to employment status; in Suffolk, the percentage of people who are classified as inactive in those that are in fulltime employment is 17.9% whilst this figure is significantly higher at 41.9% in those that were unemployed (Sport England, 2016c).

In the most recent Global Burden of Disease findings, physical inactivity has been categorised as one of the top ten causes of disease and disability in England (Newton et al., 2015). It has been estimated that 37,000 deaths a year could be prevented in England if everyone met the CMO’s physical activity guidelines for adults (UK Active, 2014). Physical activity, has been proven to reduce the risk of many diseases and conditions including cardiovascular disease; type 2 diabetes; certain cancers; depression and dementia (Varney et al., 2014; Department of Health, 2011b). The biggest overall contributor to Disability Adjusted Life Years (DALY’s) is the combination of physical inactivity, high Body Mass Index (BMI) and unhealthy diets (Newton et al., 2015). It has been estimated that each year in Suffolk 1,368 years are living with disability due to low levels of PA alone (Murray et al., 2013).

According to the National Travel Survey (NTS) for England 2015 (Sullivan-Kathryn & Cummings, 2016), The car is the most common mode of transport used (64% of the trips), and walking and cycling constitute only 22% & 2%, respectively, of all trips in England (Sullivan-Kathryn & Cummings, 2016). The Suffolk Children and Young People’s Health and Wellbeing survey 2015 showed that in Suffolk primary school children 49% walked to school, 8% cycled to school and 39% were driven in motorised transport and in secondary school children 30% walked to school, 2% cycled to school and 32% were driven in motorised transport (SHEU, 2015). A few of the predictors of active travel in school age children included availability of cycle paths, width of pavements, perceived neighbourhood safety, distance from school (<1km), mothers who actively commute, dangerous traffic en-route and general concern for child safety (Panter, Jones, Van Sluijs, Griffin, & Panter, 2009).

In terms of active travel in adults, Suffolk is ranked 25/89 for the proportion of the population who cycle at least three times per week for at least ten minutes at a time and 33/89 for walking in comparison with all upper tier and unitary authorities excluding London boroughs in 2014/15 (Department for Transport, 2016). In Suffolk, the proportion of the population regularly walking is 80.8% walking at least once a week, 61.7% walking at least 3 times a week and 49.1% walking at least 5 times a week. Cycling levels in Suffolk are on average slightly above those for England and indicate
that 10.8% cycle at least once a week, 5.4% cycle at least 3 times a week and 2.6% walking at least 5 times a week (Department for Transport, 2016).

PA improves both mental and physical well-being, and when performed in an outdoor environment additional mental health and physiological benefits are gained (Gladwell, Brown, Wood, Sandercock, & Barton, 2013). The evidence also suggests there are a wide variety of benefits for children as a result of being active outdoors, including improved motor co-ordination and physical skills, improved concentration and reduced stress and anxiety (Woolley, Pattacini, & Somerset-ward, 2009).

Activity in the green environment improves both physical and mental wellbeing in adults. A dose-response relationship exists and it has been shown that visits to outdoor green spaces of 30 minutes or more during a week can reduce population prevalence of depression by up to 7% and high blood pressure by up to 9% (Shanahan et al., 2016). Sport England recently identified that of the 43.7m total adult population in England, 18.2m who are not currently active outdoors want to re-engage in outdoor activity in the next 12 months.”(Sport England, 2015; “Sporting Future: A New Strategy for an Active Nation SportingFuture,” 2015). The natural environment is undoubtedly one of Suffolk’s key strengths. Almost 50% of Suffolk residents identified that they use outdoor areas for most of their physical activity and over 20% perform up to half of their PA in outdoor areas (SAPAS).

The cost to society of physical inactivity not only comes from the direct costs of treating diseases but also the indirect costs to the economy for example as a result absenteeism at work (UK Active, 2014). An increase in savings by increasing participation in PA may be achieved by reducing barriers to PA participation such as; developing green spaces, reducing inequalities and increasing active travel (UK Active, 2014). It is estimated that within Suffolk, there are 244.6 premature deaths per 100,000 people per year attributed to physical inactivity and that the cost of inactivity per year to Suffolk per 100,000 people is £17,718,700 (UK Active, 2014).

Physical activity is an important factor in many key local policies and strategies that are informed and aligned to national frameworks and policy. Physical activity impacts across the whole system and this is reflected in the breadth of the policies that contribute to the physical activity agenda in Suffolk. Suffolk’s Joint Health and Wellbeing Strategy 2012–2022, which sets the long term strategic framework for improving health and wellbeing in Suffolk outlines the key priorities that physical activity can support.

The key aims of Sport England are consistent with the objectives of the government strategy (“Sporting Future: A New Strategy for an Active Nation SportingFuture,” 2015) through which, physical wellbeing, mental wellbeing, individual development, social and community development and economic development is the ultimate goal at both an individual and population level(“Sporting Future: A New Strategy for an Active Nation SportingFuture,” 2015). The recommendations of this physical activity needs assessment have been aligned to these priorities and endeavour to cover PA needs at a population and individual level for Suffolk and embed principles of behaviour change across all sectors. The recommendations follow a life course approach for the physical and mental wellbeing recommendations; Children and Young people, Working-age adults and Older Adults and social and community development recommendations include the environment, health inequalities and education as subcategories.
The recommendations highlight that for children and young people, both they and their families need to be supported to increase their participation in everyday opportunities to be more physical activity, at home and whilst at school. Furthermore, inequalities should be addressed in terms of gender differences, those with higher weight and those with lower levels of emotional and mental wellbeing. For working age adults, effort to reduce inactivity in this cohort must focus on reducing identified barriers to PA participation relevant to their age, gender, health status and social circumstances. Support for older adults should recognise that PA needs to be both affordable and accessible in terms of both disability and locality and consider the changing health needs of this age group. All age groups would benefit from the physical and mental wellbeing advantages of being active outdoors. It recommended that PA can be used as part of a strategy to address key mental wellbeing issues for each cohort, including social and behavioural issues in young people, stress in working age adults and social isolation and loneliness in older adults. Sedentary behaviour can negatively affect health and affects all age groups and therefore opportunities and activities that seek to minimise extended periods of sitting should be explored.

In order to achieve sustained and population level behaviour change with respect to PA it will be essential to ensure that there is good understanding of the importance, benefits and recommended guidelines for PA by the general public and workforce, in particular those working in healthcare and other allied professions. Initiatives are required that will promote and encourage continued engagement with PA in underrepresented, such as women, carers and those with a limiting illness or disability. It is important that local co-production and engagement is at the centre of any interventions in order to address community and local need.

Fundamentally, all interventions and programmes should have planned evaluation incorporated at the earliest opportunity to ensure best practice can be established and informed decision-making undertaken. In addition, a whole systems approach to PA will be essential in order to gain the greatest impact, positive change and benefit to the population of Suffolk.
### Recommendations: to address local physical activity, exercise, and sports need

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<tr>
<th>LIFECOURSE WELLBEING RECOMMENDATIONS</th>
<th>PHYSICAL WELLBEING</th>
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| **CYP**                             | 1. Children and their families need to be supported to be more physically active through active recreation, active travel and active play.  
2. The increasingly earlier disengagement of girls from participation in sport and PA needs to be tackled  
3. PA programmes should support the needs of children with excess weight  
4. Sedentary behaviour both in school and at home needs to be reduced | 1. PA should be used to support emotional health and to prevent mental ill health, in particular that associated with anxiety, depression and exam related stress.  
2. Opportunities that utilise outdoor green space to be active should be explored as these may offer particular benefits to those with specific conditions including but not limited to ADD, stress, anxiety and behavioural issues. |  |
| **Working age adults**               | 1. Efforts should be made to reduce the identified barriers to PA participation in working age adults relevant to their age, gender, health status and social circumstances.  
2. Opportunities should be sought to reduce sedentary behaviour both in the workplace and at home. | 1. Employees should be supported by their employers and appropriate policies and programmes to incorporate PA as part of their working day to support good physical and mental health.  
2. Prevention/early intervention strategies for mental health problems should include physical activity. |  |
| **Older Adults**                    | 1. The opportunity to take part in PA needs to be affordable and accessible particularly for older people (in terms of both disability and locality)  
2. PA interventions should be encouraged that prevent falls, reduce risk of dementia, maintain physical independence and promote good physical health.  
3. There needs to be targeted education and promotion of the benefits and guidelines for PA participation in older people; endorsing the underlying principle that it’s “never too late to get active”. | 1. Opportunities need to be developed that use PA participation to help reduce social isolation and loneliness  
2. Mental and physical wellbeing can be supported by creating an environment that increases opportunities to be active outdoors in either urban or rural settings. |  |

**EVALUATION of impact and outcomes is essential**
## DEVELOPMENT RECOMMENDATIONS

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<th>SOCIAL AND COMMUNITY</th>
<th>ECONOMIC</th>
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| 1. In order to ensure long-term sustainability a comprehensive approach to supporting PA participation with an appropriately skilled paid and volunteer work force is required. | HEALTH INEQUALITIES  
1. Community projects co-produced with input from local people should be developed to strengthen and empower local people to engage in regular PA.  
2. Initiatives are required that will promote and encourage continued engagement with PA from women throughout the life course.  
3. Due to the link between low PA and lower socio-economic status access to free and low-cost physical activity opportunities is necessary.  
4. Support is required to encourage under-represented groups to engage in PA; this includes but is not limited to BAME, LGBT, carers, those with disabilities and others. | 1. A collaborative and co-ordinated approach to tackle physical inactivity is required across the wider system that is supported by senior leadership. Strategic oversight should be provided by HWB and/or strategic steering group with key partners.  
2. Policy and action should support increasing healthy life expectancy through prevention and early intervention.  
3. Programmes/interventions to tackle inactivity need to be sustainable and be embedded with behaviour change principles.  
4. Sporting events and businesses that promote PA through participating, spectating and volunteering that bring economic gain to Suffolk should be supported. |
| 2. The principals of behaviour change need to be embedded at an individual level to create personal resilience and should be incorporated into new innovations with respect to engaging individuals in.  
3. A comprehensive understanding and appreciation of the holistic benefits of PA should be gained through educational promotion at all stages of the life course.  
4. It is necessary to work to reduce the barriers to PA participation and support individuals to have the knowledge, skills, and confidence to get and stay active. | ENVIRONMENT  
1. Strategies to make walking and cycling the default choice for shorter journeys as identified in the cycling and walking strategy need to continue to be supported and implemented.  
2. Integrated travel options that incorporate cycling and/or walking for part of the journey and promote active commuting need to be explored.  
3. The opportunities provided by Suffolk’s natural landscape should continue to be used to promote PA in the outdoor environment. | |
|  | EDUCATION  
1. Promotion of the CMO guidelines for PA across the life course is required to improve knowledge, understanding and the benefits of participating in regular PA and reducing sedentary behaviour. This should be targeted to the general public, healthcare professionals and other allied partners. |  | |
|  | EVALUATION of impact and outcomes is essential |  | |